

SB 6364 - H COMM AMD

By Committee on Health Care & Wellness

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** The intent of this chapter is to promote
4 the public interest, support the availability of long-term care
5 coverage, establish standards for long-term care coverage, facilitate
6 public understanding and comparison of long-term care contract
7 benefits, protect persons insured under long-term care insurance
8 policies and certificates, protect applicants for long-term care
9 policies from unfair or deceptive sales or enrollment practices, and
10 provide for flexibility and innovation in the development of long-term
11 care insurance coverage.

12 NEW SECTION. **Sec. 2.** This chapter applies to all long-term care
13 insurance policies, contracts, or riders delivered or issued for
14 delivery in this state on or after January 1, 2009. This chapter does
15 not supersede the obligations of entities subject to this chapter to
16 comply with other applicable laws to the extent that they do not
17 conflict with this chapter, except that laws and regulations designed
18 and intended to apply to medicare supplement insurance policies shall
19 not be applied to long-term care insurance.

20 (1) Coverage advertised, marketed, or offered as long-term care
21 insurance shall comply with the provisions of this chapter. Any
22 coverage, policy, or rider advertised, marketed, or offered as long-
23 term care or nursing home insurance shall comply with the provisions of
24 this chapter.

25 (2) Individual and group long-term care contracts issued prior to
26 January 1, 2009, remain governed by chapter 48.84 RCW and rules adopted
27 thereunder.

28 (3) This chapter is not intended to prohibit approval of long-term
29 care funded through life insurance.

1 NEW SECTION. **Sec. 3.** The definitions in this section apply
2 throughout this chapter unless the context clearly requires otherwise.

3 (1) "Applicant" means: (a) In the case of an individual long-term
4 care insurance policy, the person who seeks to contract for benefits;
5 and (b) in the case of a group long-term care insurance policy, the
6 proposed certificate holder.

7 (2) "Certificate" includes any certificate issued under a group
8 long-term care insurance policy that has been delivered or issued for
9 delivery in this state.

10 (3) "Commissioner" means the insurance commissioner of Washington
11 state.

12 (4) "Issuer" includes insurance companies, fraternal benefit
13 societies, health care service contractors, health maintenance
14 organizations, or other entity delivering or issuing for delivery any
15 long-term care insurance policy, contract, or rider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (7) "Policy" includes a document such as an insurance policy,
15 contract, subscriber agreement, rider, or endorsement delivered or
16 issued for delivery in this state by an insurer, fraternal benefit
17 society, health care service contractor, health maintenance
18 organization, or any similar entity authorized by the insurance
19 commissioner to transact the business of long-term care insurance.

20 (8) "Qualified long-term care insurance contract" or "federally
21 tax-qualified long-term care insurance contract" means:

22 (a) An individual or group insurance contract that meets the
23 requirements of section 7702B(b) of the internal revenue code of 1986,
24 as amended; or

25 (b) The portion of a life insurance contract that provides long-
26 term care insurance coverage by rider or as part of the contract and
27 that satisfies the requirements of sections 7702B(b) and (e) of the
28 internal revenue code of 1986, as amended.

29 NEW SECTION. **Sec. 4.** A group long-term care insurance policy may
30 not be offered to a resident of this state under a group policy issued
31 in another state to a group described in section 3(6)(d) of this act,
32 unless this state or another state having statutory and regulatory
33 long-term care insurance requirements substantially similar to those
34 adopted in this state has made a determination that such requirements
35 have been met.

1 NEW SECTION. **Sec. 5.** (1) A long-term care insurance policy or
2 certificate may not define "preexisting condition" more restrictively
3 than as a condition for which medical advice or treatment was
4 recommended by or received from a provider of health care services,
5 within six months preceding the effective date of coverage of an
6 insured person, unless the policy or certificate applies to group long-
7 term care insurance under section 3(6) (a), (b), or (c) of this act.

8 (2) A long-term care insurance policy or certificate may not
9 exclude coverage for a loss or confinement that is the result of a
10 preexisting condition unless the loss or confinement begins within six
11 months following the effective date of coverage of an insured person,
12 unless the policy or certificate applies to a group as defined in
13 section 3(6)(a) of this act.

14 (3) The commissioner may extend the limitation periods for specific
15 age group categories in specific policy forms upon finding that the
16 extension is in the best interest of the public.

17 (4) An issuer may use an application form designed to elicit the
18 complete health history of an applicant and underwrite in accordance
19 with that issuer's established underwriting standards, based on the
20 answers on that application. Unless otherwise provided in the policy
21 or certificate and regardless of whether it is disclosed on the
22 application, a preexisting condition need not be covered until the
23 waiting period expires.

24 (5) A long-term care insurance policy or certificate may not
25 exclude or use waivers or riders to exclude, limit, or reduce coverage
26 or benefits for specifically named or described preexisting diseases or
27 physical conditions beyond the waiting period.

28 NEW SECTION. **Sec. 6.** No long-term care insurance policy may:

29 (1) Be canceled, nonrenewed, or otherwise terminated on the grounds
30 of the age or the deterioration of the mental or physical health of the
31 insured individual or certificate holder;

32 (2) Contain a provision establishing a new waiting period in the
33 event existing coverage is converted to or replaced by a new or other
34 form within the same company, except with respect to an increase in
35 benefits voluntarily selected by the insured individual or group
36 policyholder;

1 (3) Provide coverage for skilled nursing care only or provide
2 significantly more coverage for skilled care in a facility than
3 coverage for lower levels of care;

4 (4) Condition eligibility for any benefits on a prior
5 hospitalization requirement;

6 (5) Condition eligibility for benefits provided in an institutional
7 care setting on the receipt of a higher level of institutional care;

8 (6) Condition eligibility for any benefits other than waiver of
9 premium, postconfinement, postacute care, or recuperative benefits on
10 a prior institutionalization requirement;

11 (7) Include a postconfinement, postacute care, or recuperative
12 benefit unless:

13 (a) Such requirement is clearly labeled in a separate paragraph of
14 the policy or certificate entitled "Limitations or Conditions on
15 Eligibility for Benefits;" and

16 (b) Such limitations or conditions specify any required number of
17 days of preconfinement or postconfinement;

18 (8) Condition eligibility for noninstitutional benefits on the
19 prior receipt of institutional care;

20 (9) A long-term care insurance policy or certificate may be field-
21 issued if the compensation to the field issuer is not based on the
22 number of policies or certificates issued. For purposes of this
23 section, "field-issued" means a policy or certificate issued by a
24 producer or a third-party administrator of the policy pursuant to the
25 underwriting authority by an issuer and using the issuer's underwriting
26 guidelines.

27 NEW SECTION. **Sec. 7.** (1) Long-term care insurance applicants may
28 return a policy or certificate for any reason within thirty days after
29 its delivery and to have the premium refunded.

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

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

1 (4) This section shall not apply to certificates issued pursuant to
2 a policy issued to a group defined in section 3(6)(a) of this act.

3 NEW SECTION. **Sec. 8.** (1) An outline of coverage must be delivered
4 to a prospective applicant for long-term care insurance at the time of
5 initial solicitation through means that prominently direct the
6 attention of the recipient to the document and its purpose.

7 (a) The commissioner must prescribe a standard format, including
8 style, arrangement, overall appearance, and the content of an outline
9 of coverage.

10 (b) When an insurance producer makes a solicitation in person, he
11 or she must deliver an outline of coverage before presenting an
12 application or enrollment form.

13 (c) In a direct response solicitation, the outline of coverage must
14 be presented with an application or enrollment form.

15 (d) If a policy is issued to a group as defined in section 3(6)(a)
16 of this act, an outline of coverage is not required to be delivered, if
17 the information that the commissioner requires to be included in the
18 outline of coverage is in other materials relating to enrollment. Upon
19 request, any such materials must be made available to the commissioner.

20 (2) If an issuer approves an application for a long-term care
21 insurance contract or certificate, the issuer must deliver the contract
22 or certificate of insurance to the applicant within thirty days after
23 the date of approval. A policy summary must be delivered with an
24 individual life insurance policy that provides long-term care benefits
25 within the policy or by rider. In a direct response solicitation, the
26 issuer must deliver the policy summary, upon request, before delivery
27 of the policy, if the applicant requests a summary.

28 (a) The policy summary shall include:

29 (i) An explanation of how the long-term care benefit interacts with
30 other components of the policy, including deductions from any
31 applicable death benefits;

32 (ii) An illustration of the amount of benefits, the length of
33 benefits, and the guaranteed lifetime benefits if any, for each covered
34 person;

35 (iii) Any exclusions, reductions, and limitations on benefits of
36 long-term care;

1 (iv) A statement that any long-term care inflation protection
2 option required by section 12 of this act is not available under this
3 policy; and

4 (v) If applicable to the policy type, the summary must also
5 include:

6 (A) A disclosure of the effects of exercising other rights under
7 the policy;

8 (B) A disclosure of guarantees related to long-term care costs of
9 insurance charges; and

10 (C) Current and projected maximum lifetime benefits.

11 (b) The provisions of the policy summary may be incorporated into
12 a basic illustration required under chapter 48.23A RCW, or into the
13 policy summary which is required under rules adopted by the
14 commissioner.

15 NEW SECTION. **Sec. 9.** If a long-term care benefit funded through
16 a life insurance policy by the acceleration of the death benefit is in
17 benefit payment status, a monthly report must be provided to the
18 policyholder. The report must include:

19 (1) A record of all long-term care benefits paid out during the
20 month;

21 (2) An explanation of any changes in the policy resulting from
22 paying the long-term care benefits, such as a change in the death
23 benefit or cash values; and

24 (3) The amount of long-term care benefits that remain to be paid.

25 NEW SECTION. **Sec. 10.** All long-term care denials must be made
26 within sixty days after receipt of a written request made by a
27 policyholder or certificate holder, or his or her representative. All
28 denials of long-term care claims by the issuer must provide a written
29 explanation of the reasons for the denial and make available to the
30 policyholder or certificate holder all information directly related to
31 the denial.

32 NEW SECTION. **Sec. 11.** (1) An issuer may rescind a long-term care
33 insurance policy or certificate or deny an otherwise valid long-term
34 care insurance claim if:

1 (a) A policy or certificate has been in force for less than six
2 months and upon a showing of misrepresentation that is material to the
3 acceptance for coverage; or

4 (b) A policy or certificate that has been in force for at least six
5 months but less than two years, upon a showing of misrepresentation
6 that is both material to the acceptance for coverage and that pertains
7 to the condition for which benefits are sought.

8 (2) After a policy or certificate has been in force for two years
9 it is not contestable upon the grounds of misrepresentation alone.
10 Such a policy or certificate may be contested only upon a showing that
11 the insured knowingly and intentionally misrepresented relevant facts
12 relating to the insured's health.

13 (3) An issuer's payments for benefits under a long-term care
14 insurance policy or certificate may not be recovered by the issuer if
15 the policy or certificate is rescinded.

16 (4) This section does not apply to the remaining death benefit of
17 a life insurance policy that accelerates benefits for long-term care
18 that are governed by RCW 48.23.050 the state's life insurance
19 incontestability clause. In all other situations, this section shall
20 apply to life insurance policies that accelerate benefits for long-term
21 care.

22 NEW SECTION. **Sec. 12.** (1) The commissioner must establish minimum
23 standards for inflation protection features.

24 (2) An issuer must comply with the rules adopted by the
25 commissioner that establish minimum standards for inflation protection
26 features.

27 NEW SECTION. **Sec. 13.** (1) Except as provided by this section, a
28 long-term care insurance policy may not be delivered or issued for
29 delivery in this state unless the policyholder or certificate holder
30 has been offered the option of purchasing a policy or certificate that
31 includes a nonforfeiture benefit. The offer of a nonforfeiture benefit
32 may be in the form of a rider that is attached to the policy. If a
33 policyholder or certificate holder declines the nonforfeiture benefit,
34 the issuer must provide a contingent benefit upon lapse that is
35 available for a specified period of time following a substantial
36 increase in premium rates.

1 (2) If a group long-term care insurance policy is issued, the offer
2 required in subsection (1) of this section must be made to the group
3 policyholder. However, if the policy is issued as group long-term care
4 insurance as defined in section 3(6)(d) of this act other than to a
5 continuing care retirement community or other similar entity, the
6 offering shall be made to each proposed certificate holder.

7 (3) The commissioner must adopt rules specifying the type or types
8 of nonforfeiture benefits to be offered as part of long-term care
9 insurance policies and certificates, the standards for nonforfeiture
10 benefits, and the rules regarding contingent benefit upon lapse,
11 including a determination of the specified period of time during which
12 a contingent benefit upon lapse will be available and the substantial
13 premium rate increase that triggers a contingent benefit upon lapse.

14 NEW SECTION. **Sec. 14.** A person may not sell, solicit, or
15 negotiate long-term care insurance unless he or she is appropriately
16 licensed as an insurance producer and has successfully completed
17 long-term care coverage education that meets the requirements of this
18 section.

19 (1) All long-term care education required by this chapter must meet
20 the requirements of chapter 48.17 RCW and rules adopted by the
21 commissioner.

22 (2)(a)(i) After January 1, 2009, prior to soliciting, selling, or
23 negotiating long-term care insurance coverage, an insurance producer
24 must successfully complete a one-time education course consisting of no
25 fewer than eight hours on long-term care coverage, long-term care
26 services, state and federal regulations and requirements for long-term
27 care and qualified long-term care insurance coverage, changes or
28 improvements in long-term care services or providers, alternatives to
29 the purchase of long-term care insurance coverage, the effect of
30 inflation on benefits and the importance of inflation protection, and
31 consumer suitability standards and guidelines.

32 (ii) In order to continue soliciting, selling, or negotiating
33 long-term care coverage in this state, all insurance producers selling,
34 soliciting, or negotiating long-term care insurance coverage prior to
35 the effective date of this act must successfully complete the
36 eight-hour, one-time long-term care education and training course no
37 later than July 1, 2009.

1 (b) In addition to the one-time education and training requirement
2 set forth in (a) of this subsection, insurance producers who engage in
3 the solicitation, sale, or negotiation of long-term care insurance
4 coverage must successfully complete no fewer than four hours every
5 twenty-four months of continuing education specific to long-term care
6 insurance coverage and issues. Long-term care insurance coverage
7 continuing education shall consist of topics related to long-term care
8 insurance, long-term care services, and, if applicable, qualified state
9 long-term care insurance partnership programs, including, but not
10 limited to, the following:

11 (i) State and federal regulations and requirements and the
12 relationship between qualified state long-term care insurance
13 partnership programs and other public and private coverage of long-term
14 care services, including medicaid;

15 (ii) Available long-term care services and providers;

16 (iii) Changes or improvements in long-term care services or
17 providers;

18 (iv) Alternatives to the purchase of private long-term care
19 insurance;

20 (v) The effect of inflation on benefits and the importance of
21 inflation protection;

22 (vi) This chapter and chapters 48.84 and 48.85 RCW; and

23 (vii) Consumer suitability standards and guidelines.

24 (3) The insurance producer education required by this section shall
25 not include training that is issuer or company product-specific or that
26 includes any sales or marketing information, materials, or training,
27 other than those required by state or federal law.

28 (4) Issuers shall obtain verification that an insurance producer
29 receives training required by this section before that producer is
30 permitted to sell, solicit, or otherwise negotiate the issuer's long-
31 term care insurance products.

32 (5) Issuers shall maintain records subject to the state's record
33 retention requirements and shall make evidence of that verification
34 available to the commissioner upon request.

35 (6)(a) Issuers shall maintain records with respect to the training
36 of its producers concerning the distribution of its long-term care
37 partnership policies that will allow the commissioner to provide
38 assurance to the state department of social and health services,

1 medicaid division, that insurance producers engaged in the sale of
2 long-term care insurance contracts have received the training required
3 by this section and any rules adopted by the commissioner, and that
4 producers have demonstrated an understanding of the partnership
5 policies and their relationship to public and private coverage of long-
6 term care, including medicaid, in this state.

7 (b) These records shall be maintained in accordance with the
8 state's record retention requirements and shall be made available to
9 the commissioner upon request.

10 (7) The satisfaction of these training requirements for any state
11 shall be deemed to satisfy the training requirements of this state.

12 NEW SECTION. **Sec. 15.** Issuers and their agents, if any, must
13 determine whether issuing long-term care insurance coverage to a
14 particular person is appropriate, except in the case of a life
15 insurance policy that accelerates benefits for long-term care.

16 (1) An issuer must:

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

20 (b) Train its agents in the use of the issuer's suitability
21 standards; and

22 (c) Maintain a copy of its suitability standards and make the
23 standards available for inspection, upon request.

24 (2) The following must be considered when determining whether the
25 applicant meets the issuer's suitability standards:

26 (a) The ability of the applicant to pay for the proposed coverage
27 and any other relevant financial information related to the purchase of
28 or payment for coverage;

29 (b) The applicant's goals and needs with respect to long-term care
30 and the advantages and disadvantages of long-term care coverage to meet
31 those goals or needs; and

32 (c) The values, benefits, and costs of the applicant's existing
33 health or long-term care coverage, if any, when compared to the values,
34 benefits, and costs of the recommended purchase or replacement.

35 (3) The sale or transfer of any suitability information provided to
36 the issuer or agent by the applicant to any other person or business
37 entity is prohibited.

1 (4)(a) The commissioner shall adopt, by rule, forms of consumer-
2 friendly personal worksheets that issuers and their agents must use for
3 applications for long-term care coverage.

4 (b) The commissioner may require each issuer to file its current
5 forms of suitability standards and personal worksheets with the
6 commissioner.

7 NEW SECTION. **Sec. 16.** A person engaged in the issuance or
8 solicitation of long-term care coverage shall not engage in unfair
9 methods of competition or unfair or deceptive acts or practices, as
10 such methods, acts, or practices are defined in chapter 48.30 RCW, or
11 as defined by the commissioner.

12 NEW SECTION. **Sec. 17.** An issuer or an insurance producer who
13 violates a law or rule relating to the regulation of long-term care
14 insurance or its marketing shall be subject to a fine of up to three
15 times the amount of the commission paid for each policy involved in the
16 violation or up to ten thousand dollars, whichever is greater.

17 NEW SECTION. **Sec. 18.** (1) The commissioner must adopt rules that
18 include standards for full and fair disclosure setting forth the
19 manner, content, and required disclosures for the sale of long-term
20 care insurance policies, terms of renewability, initial and subsequent
21 conditions of eligibility, nonduplication of coverage provisions,
22 coverage of dependents, preexisting conditions, termination of
23 insurance, continuation or conversion, probationary periods,
24 limitations, exceptions, reductions, elimination periods, requirements
25 for replacement, recurrent conditions, and definitions of terms. The
26 commissioner must adopt rules establishing loss ratio standards for
27 long-term care insurance policies. The commissioner must adopt rules
28 to promote premium adequacy and to protect policyholders in the event
29 of proposed substantial rate increases, and to establish minimum
30 standards for producer education, marketing practices, producer
31 compensation, producer testing, penalties, and reporting practices for
32 long-term care insurance.

33 (2) The commissioner shall adopt rules establishing standards
34 protecting patient privacy rights, rights to receive confidential

1 health care services, and standards for an issuer's timely review of a
2 claim denial upon request of a covered person.

3 (3) The commissioner may adopt reasonable rules to effectuate any
4 provision of this chapter in accordance with the requirements of
5 chapter 34.05 RCW.

6 **Sec. 19.** RCW 48.84.010 and 1986 c 170 s 1 are each amended to read
7 as follows:

8 This chapter may be known and cited as the "long-term care
9 insurance act" and is intended to govern the content and sale of long-
10 term care insurance and long-term care benefit contracts issued before
11 January 1, 2009, as defined in this chapter. This chapter shall be
12 liberally construed to promote the public interest in protecting
13 purchasers of long-term care insurance from unfair or deceptive sales,
14 marketing, and advertising practices. The provisions of this chapter
15 shall apply in addition to other requirements of Title 48 RCW.

16 **Sec. 20.** RCW 48.43.005 and 2007 c 296 s 1 and 2007 c 259 s 32 are
17 each reenacted and amended to read as follows:

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

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

24 (2) "Basic health plan" means the plan described under chapter
25 70.47 RCW, as revised from time to time.

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

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

32 (5) "Catastrophic health plan" means:

33 (a) In the case of a contract, agreement, or policy covering a
34 single enrollee, a health benefit plan requiring a calendar year
35 deductible of, at a minimum, one thousand seven hundred fifty dollars
36 and an annual out-of-pocket expense required to be paid under the plan

1 (other than for premiums) for covered benefits of at least three
2 thousand five hundred dollars, both amounts to be adjusted annually by
3 the insurance commissioner; and

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

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

16 In July 2008, and in each July thereafter, the insurance
17 commissioner shall adjust the minimum deductible and out-of-pocket
18 expense required for a plan to qualify as a catastrophic plan to
19 reflect the percentage change in the consumer price index for medical
20 care for a preceding twelve months, as determined by the United States
21 department of labor. The adjusted amount shall apply on the following
22 January 1st.

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

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

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

35 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
36 and unmarried dependent children who qualify for coverage under the
37 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,

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

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

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

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

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

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

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

28 (a) Long-term care insurance governed by chapter 48.84 ((RCW)) or
29 48.-- RCW (sections 1 through 18 of this act);

30 (b) Medicare supplemental health insurance governed by chapter
31 48.66 RCW;

32 (c) Coverage supplemental to the coverage provided under chapter
33 55, Title 10, United States Code;

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

36 (e) Disability income;

37 (f) Coverage incidental to a property/casualty liability insurance

1 policy such as automobile personal injury protection coverage and
2 homeowner guest medical;

3 (g) Workers' compensation coverage;

4 (h) Accident only coverage;

5 (i) Specified disease or illness-triggered fixed payment insurance,
6 hospital confinement fixed payment insurance, or other fixed payment
7 insurance offered as an independent, noncoordinated benefit;

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

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

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

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

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

23 (22) "Premium" means all sums charged, received, or deposited by a
24 health carrier as consideration for a health plan or the continuance of
25 a health plan. Any assessment or any "membership," "policy,"
26 "contract," "service," or similar fee or charge made by a health
27 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 (23) "Review organization" means a disability insurer regulated
31 under chapter 48.20 or 48.21 RCW, health care service contractor as
32 defined in RCW 48.44.010, or health maintenance organization as defined
33 in RCW 48.46.020, and entities affiliated with, under contract with, or
34 acting on behalf of a health carrier to perform a utilization review.

35 (24) "Small employer" or "small group" means any person, firm,
36 corporation, partnership, association, political subdivision, sole
37 proprietor, or self-employed individual that is actively engaged in
38 business that, on at least fifty percent of its working days during the

1 preceding calendar quarter, employed at least two but no more than
2 fifty eligible employees, with a normal work week of thirty or more
3 hours, the majority of whom were employed within this state, and is not
4 formed primarily for purposes of buying health insurance and in which
5 a bona fide employer-employee relationship exists. In determining the
6 number of eligible employees, companies that are affiliated companies,
7 or that are eligible to file a combined tax return for purposes of
8 taxation by this state, shall be considered an employer. Subsequent to
9 the issuance of a health plan to a small employer and for the purpose
10 of determining eligibility, the size of a small employer shall be
11 determined annually. Except as otherwise specifically provided, a
12 small employer shall continue to be considered a small employer until
13 the plan anniversary following the date the small employer no longer
14 meets the requirements of this definition. A self-employed individual
15 or sole proprietor must derive at least seventy-five percent of his or
16 her income from a trade or business through which the individual or
17 sole proprietor has attempted to earn taxable income and for which he
18 or she has filed the appropriate internal revenue service form 1040,
19 schedule C or F, for the previous taxable year except for a self-
20 employed individual or sole proprietor in an agricultural trade or
21 business, who must derive at least fifty-one percent of his or her
22 income from the trade or business through which the individual or sole
23 proprietor has attempted to earn taxable income and for which he or she
24 has filed the appropriate internal revenue service form 1040, for the
25 previous taxable year. A self-employed individual or sole proprietor
26 who is covered as a group of one on the day prior to June 10, 2004,
27 shall also be considered a "small employer" to the extent that
28 individual or group of one is entitled to have his or her coverage
29 renewed as provided in RCW 48.43.035(6).

30 (25) "Utilization review" means the prospective, concurrent, or
31 retrospective assessment of the necessity and appropriateness of the
32 allocation of health care resources and services of a provider or
33 facility, given or proposed to be given to an enrollee or group of
34 enrollees.

35 (26) "Wellness activity" means an explicit program of an activity
36 consistent with department of health guidelines, such as, smoking
37 cessation, injury and accident prevention, reduction of alcohol misuse,
38 appropriate weight reduction, exercise, automobile and motorcycle

1 safety, blood cholesterol reduction, and nutrition education for the
2 purpose of improving enrollee health status and reducing health service
3 costs.

4 **Sec. 21.** RCW 48.85.010 and 1995 1st sp.s. c 18 s 76 are each
5 amended to read as follows:

6 The department of social and health services shall, in conjunction
7 with the office of the insurance commissioner, coordinate a long-term
8 care insurance program entitled the Washington long-term care
9 partnership, whereby private insurance and medicaid funds shall be used
10 to finance long-term care. For individuals purchasing a long-term care
11 insurance policy or contract governed by chapter 48.84 ((RCW)) or 48.--
12 RCW (sections 1 through 18 of this act) and meeting the criteria
13 prescribed in this chapter, and any other terms as specified by the
14 office of the insurance commissioner and the department of social and
15 health services, this program shall allow for the exclusion of some or
16 all of the individual's assets in determination of medicaid eligibility
17 as approved by the federal health care financing administration.

18 NEW SECTION. **Sec. 22.** Sections 1 through 18 of this act
19 constitute a new chapter in Title 48 RCW.

20 NEW SECTION. **Sec. 23.** If any provision of this act or its
21 application to any person or circumstance is held invalid, the
22 remainder of the act or the application of the provision to other
23 persons or circumstances is not affected.

24 NEW SECTION. **Sec. 24.** This act takes effect January 1, 2009."

25 Correct the title.

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