

CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 2666

60th Legislature
2008 Regular Session

Passed by the House March 8, 2008
Yeas 93 Nays 0

Speaker of the House of Representatives

Passed by the Senate March 4, 2008
Yeas 48 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 2666** 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**

SUBSTITUTE HOUSE BILL 2666

AS AMENDED BY THE SENATE

Passed Legislature - 2008 Regular Session

State of Washington 60th Legislature 2008 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Morrell, Cody, McCoy, Green, Hunt, Wallace, Pedersen, Moeller, McIntire, Barlow, Conway, Simpson, and Darneille)

READ FIRST TIME 02/04/08.

1 AN ACT Relating to long-term care insurance; amending RCW 48.84.010
2 and 48.85.010; reenacting and amending RCW 48.43.005; adding a new
3 chapter to Title 48 RCW; prescribing penalties; and providing an
4 effective date.

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

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

15 NEW SECTION. **Sec. 2.** This chapter applies to all long-term care
16 insurance policies, contracts, or riders delivered or issued for
17 delivery in this state on or after January 1, 2009. This chapter does
18 not supersede the obligations of entities subject to this chapter to

1 comply with other applicable laws to the extent that they do not
2 conflict with this chapter, except that laws and regulations designed
3 and intended to apply to medicare supplement insurance policies shall
4 not be applied to long-term care insurance.

5 (1) Coverage advertised, marketed, or offered as long-term care
6 insurance shall comply with the provisions of this chapter. Any
7 coverage, policy, or rider advertised, marketed, or offered as long-
8 term care or nursing home insurance shall comply with the provisions of
9 this chapter.

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

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

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

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

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

24 (3) "Commissioner" means the insurance commissioner of Washington
25 state.

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

30 (5) "Long-term care insurance" means an insurance policy, contract,
31 or rider that is advertised, marketed, offered, or designed to provide
32 coverage for at least twelve consecutive months for a covered person.
33 Long-term care insurance maybe on an expense incurred, indemnity,
34 prepaid, or other basis, for one or more necessary or medically
35 necessary diagnostic, preventive, therapeutic, rehabilitative,
36 maintenance, or personal care services, provided in a setting other
37 than an acute care unit of a hospital. Long-term care insurance

1 includes any policy, contract, or rider that provides for payment of
2 benefits based upon cognitive impairment or the loss of functional
3 capacity.

4 (a) Long-term care insurance includes group and individual
5 annuities and life insurance policies or riders that provide directly
6 or supplement long-term care insurance. However, long-term care
7 insurance does not include life insurance policies that: (i)
8 Accelerate the death benefit specifically for one or more of the
9 qualifying events of terminal illness, medical conditions requiring
10 extraordinary medical intervention, or permanent institutional
11 confinement; (ii) provide the option of a lump-sum payment for those
12 benefits; and (iii) do not condition the benefits or the eligibility
13 for the benefits upon the receipt of long-term care.

14 (b) Long-term care insurance also includes qualified long-term care
15 insurance contracts.

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

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

25 (a) One or more employers; one or more labor organizations; or a
26 trust or the trustees of a fund established by one or more employers or
27 labor organizations for current or former employees, current or former
28 members of the labor organizations, or a combination of current and
29 former employees or members, or a combination of such employers, labor
30 organizations, trusts, or trustees; or

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

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

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

37 (c)(i) An association, trust, or the trustees of a fund
38 established, created, or maintained for the benefit of members of one

1 or more associations. Before advertising, marketing, or offering long-
2 term care coverage in this state, the association or associations, or
3 the insurer of the association or associations, must file evidence with
4 the commissioner that the association or associations have at the time
5 of such filing at least one hundred persons who are members and that
6 the association or associations have been organized and maintained in
7 good faith for purposes other than that of obtaining insurance; have
8 been in active existence for at least one year; and have a constitution
9 and bylaws that provide that:

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

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

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

16 (ii) Thirty days after filing the evidence in accordance with this
17 section, the association or associations will be deemed to have
18 satisfied the organizational requirements, unless the commissioner
19 makes a finding that the association or associations do not satisfy
20 those organizational requirements.

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

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

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

27 (iii) The benefits are reasonable in relation to the premiums
28 charged.

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

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

37 (a) An individual or group insurance contract that meets the

1 requirements of section 7702B(b) of the internal revenue code of 1986,
2 as amended; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (7) Include a postconfinement, postacute care, or recuperative
25 benefit unless:

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

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

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

33 (9) A long-term care insurance policy or certificate may be field-
34 issued if the compensation to the field issuer is not based on the
35 number of policies or certificates issued. For purposes of this
36 section, "field-issued" means a policy or certificate issued by a

1 producer or a third-party administrator of the policy pursuant to the
2 underwriting authority by an issuer and using the issuer's underwriting
3 guidelines.

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

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

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

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

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

20 (a) The commissioner must prescribe a standard format, including
21 style, arrangement, overall appearance, and the content of an outline
22 of coverage.

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

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

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

33 (2) If an issuer approves an application for a long-term care
34 insurance contract or certificate, the issuer must deliver the contract
35 or certificate of insurance to the applicant within thirty days after
36 the date of approval. A policy summary must be delivered with an

1 individual life insurance policy that provides long-term care benefits
2 within the policy or by rider. In a direct response solicitation, the
3 issuer must deliver the policy summary, upon request, before delivery
4 of the policy, if the applicant requests a summary.

5 (a) The policy summary shall include:

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

9 (ii) An illustration of the amount of benefits, the length of
10 benefits, and the guaranteed lifetime benefits if any, for each covered
11 person;

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

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

17 (v) If applicable to the policy type, the summary must also
18 include:

19 (A) A disclosure of the effects of exercising other rights under
20 the policy;

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

23 (C) Current and projected maximum lifetime benefits.

24 (b) The provisions of the policy summary may be incorporated into
25 a basic illustration required under chapter 48.23A RCW, or into the
26 policy summary which is required under rules adopted by the
27 commissioner.

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

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

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

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

1 NEW SECTION. **Sec. 10.** All long-term care denials must be made
2 within sixty days after receipt of a written request made by a
3 policyholder or certificate holder, or his or her representative. All
4 denials of long-term care claims by the issuer must provide a written
5 explanation of the reasons for the denial and make available to the
6 policyholder or certificate holder all information directly related to
7 the denial.

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

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

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

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

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

26 (4) This section does not apply to the remaining death benefit of
27 a life insurance policy that accelerates benefits for long-term care
28 that are governed by RCW 48.23.050 the state's life insurance
29 incontestability clause. In all other situations, this section shall
30 apply to life insurance policies that accelerate benefits for long-term
31 care.

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

34 (2) An issuer must comply with the rules adopted by the
35 commissioner that establish minimum standards for inflation protection
36 features.

1 NEW SECTION. **Sec. 13.** (1) Except as provided by this section, a
2 long-term care insurance policy may not be delivered or issued for
3 delivery in this state unless the policyholder or certificate holder
4 has been offered the option of purchasing a policy or certificate that
5 includes a nonforfeiture benefit. The offer of a nonforfeiture benefit
6 may be in the form of a rider that is attached to the policy. If a
7 policyholder or certificate holder declines the nonforfeiture benefit,
8 the issuer must provide a contingent benefit upon lapse that is
9 available for a specified period of time following a substantial
10 increase in premium rates.

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

17 (3) The commissioner must adopt rules specifying the type or types
18 of nonforfeiture benefits to be offered as part of long-term care
19 insurance policies and certificates, the standards for nonforfeiture
20 benefits, and the rules regarding contingent benefit upon lapse,
21 including a determination of the specified period of time during which
22 a contingent benefit upon lapse will be available and the substantial
23 premium rate increase that triggers a contingent benefit upon lapse.

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

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

32 (2)(a)(i) After January 1, 2009, prior to soliciting, selling, or
33 negotiating long-term care insurance coverage, an insurance producer
34 must successfully complete a one-time education course consisting of no
35 fewer than eight hours on long-term care coverage, long-term care
36 services, state and federal regulations and requirements for long-term
37 care and qualified long-term care insurance coverage, changes or

1 improvements in long-term care services or providers, alternatives to
2 the purchase of long-term care insurance coverage, the effect of
3 inflation on benefits and the importance of inflation protection, and
4 consumer suitability standards and guidelines.

5 (ii) In order to continue soliciting, selling, or negotiating
6 long-term care coverage in this state, all insurance producers selling,
7 soliciting, or negotiating long-term care insurance coverage prior to
8 the effective date of this act must successfully complete the
9 eight-hour, one-time long-term care education and training course no
10 later than July 1, 2009.

11 (b) In addition to the one-time education and training requirement
12 set forth in (a) of this subsection, insurance producers who engage in
13 the solicitation, sale, or negotiation of long-term care insurance
14 coverage must successfully complete no fewer than four hours every
15 twenty-four months of continuing education specific to long-term care
16 insurance coverage and issues. Long-term care insurance coverage
17 continuing education shall consist of topics related to long-term care
18 insurance, long-term care services, and, if applicable, qualified state
19 long-term care insurance partnership programs, including, but not
20 limited to, the following:

21 (i) State and federal regulations and requirements and the
22 relationship between qualified state long-term care insurance
23 partnership programs and other public and private coverage of long-term
24 care services, including medicaid;

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

26 (iii) Changes or improvements in long-term care services or
27 providers;

28 (iv) Alternatives to the purchase of private long-term care
29 insurance;

30 (v) The effect of inflation on benefits and the importance of
31 inflation protection;

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

33 (vii) Consumer suitability standards and guidelines.

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

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

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

8 (6)(a) Issuers shall maintain records with respect to the training
9 of its producers concerning the distribution of its long-term care
10 partnership policies that will allow the commissioner to provide
11 assurance to the state department of social and health services,
12 medicaid division, that insurance producers engaged in the sale of
13 long-term care insurance contracts have received the training required
14 by this section and any rules adopted by the commissioner, and that
15 producers have demonstrated an understanding of the partnership
16 policies and their relationship to public and private coverage of long-
17 term care, including medicaid, in this state.

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

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

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

27 (1) An issuer must:

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

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

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

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

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

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

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

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

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

16 (b) The commissioner may require each issuer to file its current
17 forms of suitability standards and personal worksheets with the
18 commissioner.

19 NEW SECTION. **Sec. 16.** A person engaged in the issuance or
20 solicitation of long-term care coverage shall not engage in unfair
21 methods of competition or unfair or deceptive acts or practices, as
22 such methods, acts, or practices are defined in chapter 48.30 RCW, or
23 as defined by the commissioner.

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

29 NEW SECTION. **Sec. 18.** (1) The commissioner must adopt rules that
30 include standards for full and fair disclosure setting forth the
31 manner, content, and required disclosures for the sale of long-term
32 care insurance policies, terms of renewability, initial and subsequent
33 conditions of eligibility, nonduplication of coverage provisions,
34 coverage of dependents, preexisting conditions, termination of
35 insurance, continuation or conversion, probationary periods,

1 limitations, exceptions, reductions, elimination periods, requirements
2 for replacement, recurrent conditions, and definitions of terms. The
3 commissioner must adopt rules establishing loss ratio standards for
4 long-term care insurance policies. The commissioner must adopt rules
5 to promote premium adequacy and to protect policyholders in the event
6 of proposed substantial rate increases, and to establish minimum
7 standards for producer education, marketing practices, producer
8 compensation, producer testing, penalties, and reporting practices for
9 long-term care insurance.

10 (2) The commissioner shall adopt rules establishing standards
11 protecting patient privacy rights, rights to receive confidential
12 health care services, and standards for an issuer's timely review of a
13 claim denial upon request of a covered person.

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

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

19 This chapter may be known and cited as the "long-term care
20 insurance act" and is intended to govern the content and sale of long-
21 term care insurance and long-term care benefit contracts issued before
22 January 1, 2009, as defined in this chapter. This chapter shall be
23 liberally construed to promote the public interest in protecting
24 purchasers of long-term care insurance from unfair or deceptive sales,
25 marketing, and advertising practices. The provisions of this chapter
26 shall apply in addition to other requirements of Title 48 RCW.

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

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

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

35 (2) "Basic health plan" means the plan described under chapter
36 70.47 RCW, as revised from time to time.

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

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

7 (5) "Catastrophic health plan" means:

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

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

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

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

34 (6) "Certification" means a determination by a review organization
35 that an admission, extension of stay, or other health care service or
36 procedure has been reviewed and, based on the information provided,
37 meets the clinical requirements for medical necessity, appropriateness,

1 level of care, or effectiveness under the auspices of the applicable
2 health benefit plan.

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

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

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

12 (10) "Eligible employee" means an employee who works on a full-time
13 basis with a normal work week of thirty or more hours. The term
14 includes a self-employed individual, including a sole proprietor, a
15 partner of a partnership, and may include an independent contractor, if
16 the self-employed individual, sole proprietor, partner, or independent
17 contractor is included as an employee under a health benefit plan of a
18 small employer, but does not work less than thirty hours per week and
19 derives at least seventy-five percent of his or her income from a trade
20 or business through which he or she has attempted to earn taxable
21 income and for which he or she has filed the appropriate internal
22 revenue service form. Persons covered under a health benefit plan
23 pursuant to the consolidated omnibus budget reconciliation act of 1986
24 shall not be considered eligible employees for purposes of minimum
25 participation requirements of chapter 265, Laws of 1995.

26 (11) "Emergency medical condition" means the emergent and acute
27 onset of a symptom or symptoms, including severe pain, that would lead
28 a prudent layperson acting reasonably to believe that a health
29 condition exists that requires immediate medical attention, if failure
30 to provide medical attention would result in serious impairment to
31 bodily functions or serious dysfunction of a bodily organ or part, or
32 would place the person's health in serious jeopardy.

33 (12) "Emergency services" means otherwise covered health care
34 services medically necessary to evaluate and treat an emergency medical
35 condition, provided in a hospital emergency department.

36 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
37 health carriers directly providing services, health care providers, or

1 health care facilities by enrollees and may include copayments,
2 coinsurance, or deductibles.

3 (14) "Grievance" means a written complaint submitted by or on
4 behalf of a covered person regarding: (a) Denial of payment for
5 medical services or nonprovision of medical services included in the
6 covered person's health benefit plan, or (b) service delivery issues
7 other than denial of payment for medical services or nonprovision of
8 medical services, including dissatisfaction with medical care, waiting
9 time for medical services, provider or staff attitude or demeanor, or
10 dissatisfaction with service provided by the health carrier.

11 (15) "Health care facility" or "facility" means hospices licensed
12 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
13 rural health care facilities as defined in RCW 70.175.020, psychiatric
14 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
15 under chapter 18.51 RCW, community mental health centers licensed under
16 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
17 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
18 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
19 facilities licensed under chapter 70.96A RCW, and home health agencies
20 licensed under chapter 70.127 RCW, and includes such facilities if
21 owned and operated by a political subdivision or instrumentality of the
22 state and such other facilities as required by federal law and
23 implementing regulations.

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

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

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

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

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

37 (19) "Health plan" or "health benefit plan" means any policy,

1 contract, or agreement offered by a health carrier to provide, arrange,
2 reimburse, or pay for health care services except the following:

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

5 (b) Medicare supplemental health insurance governed by chapter
6 48.66 RCW;

7 (c) Coverage supplemental to the coverage provided under chapter
8 55, Title 10, United States Code;

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

11 (e) Disability income;

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

15 (g) Workers' compensation coverage;

16 (h) Accident only coverage;

17 (i) Specified disease or illness-triggered fixed payment insurance,
18 hospital confinement fixed payment insurance, or other fixed payment
19 insurance offered as an independent, noncoordinated benefit;

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

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

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

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

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

35 (22) "Premium" means all sums charged, received, or deposited by a
36 health carrier as consideration for a health plan or the continuance of
37 a health plan. Any assessment or any "membership," "policy,"
38 "contract," "service," or similar fee or charge made by a health

1 carrier in consideration for a health plan is deemed part of the
2 premium. "Premium" shall not include amounts paid as enrollee point-
3 of-service cost-sharing.

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

9 (24) "Small employer" or "small group" means any person, firm,
10 corporation, partnership, association, political subdivision, sole
11 proprietor, or self-employed individual that is actively engaged in
12 business that, on at least fifty percent of its working days during the
13 preceding calendar quarter, employed at least two but no more than
14 fifty eligible employees, with a normal work week of thirty or more
15 hours, the majority of whom were employed within this state, and is not
16 formed primarily for purposes of buying health insurance and in which
17 a bona fide employer-employee relationship exists. In determining the
18 number of eligible employees, companies that are affiliated companies,
19 or that are eligible to file a combined tax return for purposes of
20 taxation by this state, shall be considered an employer. Subsequent to
21 the issuance of a health plan to a small employer and for the purpose
22 of determining eligibility, the size of a small employer shall be
23 determined annually. Except as otherwise specifically provided, a
24 small employer shall continue to be considered a small employer until
25 the plan anniversary following the date the small employer no longer
26 meets the requirements of this definition. A self-employed individual
27 or sole proprietor must derive at least seventy-five percent of his or
28 her income from a trade or business through which the individual or
29 sole proprietor has attempted to earn taxable income and for which he
30 or she has filed the appropriate internal revenue service form 1040,
31 schedule C or F, for the previous taxable year except for a self-
32 employed individual or sole proprietor in an agricultural trade or
33 business, who must derive at least fifty-one percent of his or her
34 income from the trade or business through which the individual or sole
35 proprietor has attempted to earn taxable income and for which he or she
36 has filed the appropriate internal revenue service form 1040, for the
37 previous taxable year. A self-employed individual or sole proprietor
38 who is covered as a group of one on the day prior to June 10, 2004,

1 shall also be considered a "small employer" to the extent that
2 individual or group of one is entitled to have his or her coverage
3 renewed as provided in RCW 48.43.035(6).

4 (25) "Utilization review" means the prospective, concurrent, or
5 retrospective assessment of the necessity and appropriateness of the
6 allocation of health care resources and services of a provider or
7 facility, given or proposed to be given to an enrollee or group of
8 enrollees.

9 (26) "Wellness activity" means an explicit program of an activity
10 consistent with department of health guidelines, such as, smoking
11 cessation, injury and accident prevention, reduction of alcohol misuse,
12 appropriate weight reduction, exercise, automobile and motorcycle
13 safety, blood cholesterol reduction, and nutrition education for the
14 purpose of improving enrollee health status and reducing health service
15 costs.

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

18 The department of social and health services shall, in conjunction
19 with the office of the insurance commissioner, coordinate a long-term
20 care insurance program entitled the Washington long-term care
21 partnership, whereby private insurance and medicaid funds shall be used
22 to finance long-term care. For individuals purchasing a long-term care
23 insurance policy or contract governed by chapter 48.84 ((RCW)) or 48.--
24 RCW (sections 1 through 18 of this act) and meeting the criteria
25 prescribed in this chapter, and any other terms as specified by the
26 office of the insurance commissioner and the department of social and
27 health services, this program shall allow for the exclusion of some or
28 all of the individual's assets in determination of medicaid eligibility
29 as approved by the federal health care financing administration.

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

32 NEW SECTION. **Sec. 23.** If any provision of this act or its
33 application to any person or circumstance is held invalid, the
34 remainder of the act or the application of the provision to other

1 persons or circumstances is not affected.

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

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