

CERTIFICATION OF ENROLLMENT

HOUSE BILL 2523

Chapter 211, Laws of 2012

62nd Legislature
2012 Regular Session

INSURERS AND INSURANCE PRODUCTS

EFFECTIVE DATE: 06/07/12

Passed by the House February 10, 2012
Yeas 96 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 1, 2012
Yeas 49 Nays 0

BRAD OWEN

President of the Senate

Approved March 30, 2012, 11:22 a.m.

CHRISTINE GREGOIRE

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 **HOUSE BILL 2523** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

March 30, 2012

**Secretary of State
State of Washington**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (3) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

19 To apply for a solicitation permit the person shall:

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

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

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

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

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

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

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

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

11 (2) File with the commissioner:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (10) Which:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (3) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (c) Is a trustworthy person;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (i) Not later than the earlier of:

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (i) A carrier;

27 (ii) A utilization review agent;

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

29 (iv) A health care provider;

30 (v) A drug or device manufacturer; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (7) "Catastrophic health plan" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29 (e) Disability income;

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

33 (g) Workers' compensation coverage;

34 (h) Accident only coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (e) Consider information submitted by the enrollee;

4 (f) Investigate and resolve the appeal; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 (5) Procedures have been established to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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