H-1204.2

HOUSE BILL 1956

State of Washington 64th Legislature 2015 Regular Session

By Representative Moeller

Read first time 02/04/15. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to independent review organizations; amending RCW
2 41.05.017, 48.43.530, 48.43.545, 48.125.030, and 70.47.130;
3 reenacting and amending RCW 48.43.005; adding a new chapter to Title
4 48 RCW; repealing RCW 43.70.235 and 48.43.535; and providing an
5 effective date.

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

7 NEW SECTION. **Sec. 1.** The definitions in this section apply
8 throughout this chapter unless the context clearly requires
9 otherwise.
10 (1) "Adverse benefit determination" means a denial, reduction, or
11 termination of, or a failure to provide or make payment, in whole or
12 in part, for a benefit, including a denial, reduction, termination,
13 or failure to provide or make payment that is based on a
14 determination of an enrollee's or applicant's eligibility to
15 participate in a plan, and including, with respect to group health
16 plans, a denial, reduction, or termination of, or a failure to
17 provide or make payment, in whole or in part, for a benefit resulting
18 from the application of any utilization review, as well as a failure
19 to cover an item or service for which benefits are otherwise provided
20 because it is determined to be experimental or investigational or not
21 medically necessary or appropriate.

1 (2) "Certified independent review organization" means an
2 independent review organization certified by the office of the
3 insurance commissioner.
4 (3) "Clinical reviewer" means a physician or other health care
5 provider who is assigned to an external review case by a certified
6 independent review organization, consistent with this chapter.
7 (4) "Contract specialist" means a reviewer who deals with
8 interpretation of health plan coverage provisions. If a clinical
9 reviewer is also interpreting health plan coverage provisions, that
10 reviewer must have the qualifications required of a contract
11 specialist.
12 (5) "Covered person" means a policyholder, subscriber, enrollee,
13 or other individual participating in a health benefit plan.
14 (6) "Final adverse benefit determination" means an adverse
15 benefit determination that has been upheld by a health plan or issuer
16 at the completion of the internal appeals process, or an adverse
17 benefit determination with respect to which the internal appeals
18 process has been exhausted under the exhaustion rules described in
19 RCW 48.43.530.
20 (7) "Final external review decision" means a determination by an
21 independent review organization at the conclusion of an external
22 review.
23 (8) "Health care provider" or "provider" means:
24 (a) A person regulated under Title 18 RCW or chapter 70.127 RCW
25 to practice health or health-related services or otherwise practicing
26 health care services in this state consistent with state law; or
27 (b) An employee or agent of a person described in (a) of this
28 subsection, acting in the course and scope of his or her employment.
29 (9) "Health care service" means that service offered or provided
30 by health care facilities and health care providers relating to the
31 prevention, cure, or treatment of illness, injury, or disease.
32 (10) "Health plan" or "health benefit plan" means any policy,
33 contract, or agreement offered by an issuer to provide, arrange,
34 reimburse, or pay for health care services except the following:
35 (a) Long-term care insurance governed by chapter 48.84 or 48.83
36 RCW;
37 (b) Medicare supplemental health insurance governed by chapter
38 48.66 RCW;
39 (c) Coverage supplemental to the coverage provided under Title 10
40 U.S.C., chapter 55;

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

(11) "Issuer" has the same meaning as "health carrier" in RCW 48.43.005. "Issuer" also applies to a health plan if the health plan administers the appeal process directly or through a third party.

(12) "Reviewer" or "expert reviewer" means a clinical reviewer or a contract specialist.

(13) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to a covered person or group of covered persons.

NEW SECTION. **Sec. 2.** (1) A covered person or his or her representative may make a request for an external review by a certified independent review organization of: (a) A final adverse benefit determination; or (b) an adverse benefit determination if the issuer has exceeded the timelines provided in RCW 48.43.530 without good cause and without reaching a decision.

(2) An issuer:

1 (a) Shall inform a covered person of the right to external review
2 by a certified independent review organization and explain the
3 process to exercise that right;
4 (b) May waive a requirement that internal appeals be exhausted
5 before a covered person may proceed to an external review of an
6 adverse benefit determination; and
7 (c) May not establish a minimum dollar amount restriction as a
8 predicate for a covered person to seek external review or impose any
9 cost on the covered person for seeking external review.
10 (3) An issuer shall provide to the appropriate certified
11 independent review organization, not later than the third business
12 day after the date the issuer receives a request for review, a copy
13 of:
14 (a) Any medical records of the covered person that are relevant
15 to the review;
16 (b) Any documents used by the issuer 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 issuer in support of the appeal; and
20 (d) A list of each physician or health care provider who has
21 provided care to the covered person and who may have medical records
22 relevant to the appeal. Health information or other confidential or
23 proprietary information in the custody of an issuer may be provided
24 to a certified independent review organization, subject to rules
25 adopted by the commissioner.
26 (4) A covered person must be provided with at least five business
27 days to submit to the certified independent review organization in
28 writing additional information that the certified independent review
29 organization must consider when conducting the external review. The
30 certified independent review organization shall forward any
31 additional information submitted by a covered person to the plan or
32 issuer within one business day of receipt by the certified
33 independent review organization. Upon receipt of this information,
34 the issuer may reverse its final adverse benefit determination.
35 (5) Once a request for an external review determination has been
36 made, the certified independent review organization shall proceed to
37 a final determination, unless requested otherwise by the issuer and
38 the covered person or the covered person's representative.

(6)(a) An issuer shall continue to provide a health service to a covered person until a final determination is made under this chapter if:

(i) The dispute for which external review has been requested involves the issuer's decision to modify, reduce, or terminate an otherwise covered health service that the covered person is receiving at the time the request for review is submitted;

(ii) The issuer's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate; and

(iii) The covered person requests that the issuer continue to provide the health service during the review.

(b) If the certified independent review organization's determination affirms the issuer's decision, the covered person may be responsible for the cost of the continued health service.

NEW SECTION. **Sec. 3.** (1) A covered person or issuer may request that a certified independent review organization perform an expedited external review if the adverse benefit determination or final adverse benefit determination:

(a) Concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility; or

(b) Involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum function.

(2) The certified independent review organization shall make a final decision to uphold or reverse the issuer's or health plan's adverse benefit determination or final adverse benefit determination and notify the covered person and the issuer or health plan of the decision as expeditiously as possible, but in no event more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the certified independent review organization shall provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

NEW SECTION. **Sec. 4.** (1) Upon receipt of the information required by section 2 of this act, a certified independent review

organization's expert reviewers shall make a determination regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for a covered person.

(2) Except as provided in this subsection, the certified independent review organization shall ensure that the determination is consistent with the scope of covered benefits as outlined in the health plan.

(a) A clinical reviewer may override the health plan's medical necessity or appropriateness standards if, upon review, the reviewer determines that the standards are unreasonable or inconsistent with sound, evidence-based medical practice or experimental or investigational treatment protocols.

(b) A reviewer may make determinations about the application of general health plan coverage provisions to specific issues concerning health care services for a covered person.

(3) Only clinical reviewers may determine whether a service that is the subject of an adverse decision is medically necessary and appropriate. These determinations must be based upon their expert clinical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence and medical standards of practice in Washington state. In considering medical standards of practice within this state:

(a) Clinical reviewers may use national standards of care, absent evidence presented by the health plan or covered person that the Washington state standard of care is different; and

(b) A health care service or treatment should be considered part of the Washington state standard of practice if reviewers believe that failure to provide it would be inconsistent with that degree of care, skill, and learning expected of a reasonably prudent health care provider acting in the same or similar circumstances.

(4) When an external review requires making a determination about the application of health plan coverage provisions to issues concerning health care services for a covered person:

(a) The determination must be made by one or more contract specialists meeting any requirements determined by rule. A clinical determination of medical necessity or appropriateness, by itself, is not an interpretation of the scope of covered benefits and does not require a contract specialist;

(b) The certified independent review organization shall request additional provisions from the health plan coverage agreement in effect during the relevant period of the covered person's coverage, as necessary to have an adequate context for determinations, if the full health plan coverage agreement has not already been provided by the issuer; and

(c) The certified independent review organization and its contract specialists may assume that the contractual health plan coverage provisions themselves are consistent with this title, unless a provision of this title is the basis of the appeal and information to the contrary is presented. Primary responsibility for determining consistency with the insurance code, when at issue, rests with the insurance commissioner.

(5) A certified independent review organization shall prepare each determination on a standardized form developed by the insurance commissioner. The form must include the information provided by a clinical review pursuant to section 5(3) of this act.

(6) This chapter does not establish a standard of medical care or create or eliminate any cause of action.

NEW SECTION. **Sec. 5.** The following requirements apply to external review of cases involving experimental or investigational treatments:

(1) The certified independent review organization shall ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(2) The clinical reviewer shall consider the following information, if appropriate and available, in developing an opinion:

(a) The covered person's pertinent medical records;

(b) The attending physician or health care provider's recommendation;

(c) Consulting reports from appropriate health care providers and other documents submitted by the issuer, covered person, or covered person's representative, or the covered person's treating physician or health care provider;

(d) Whether the terms of coverage under the covered person's health benefit plan would have covered the treatment had the issuer not determined that the treatment was experimental or investigational;

1 (e) Whether the recommended or requested health care service or
2 treatment has been approved by the federal food and drug
3 administration, if applicable, for the condition; and
4 (f) Whether medical or scientific evidence or evidence-based
5 standards demonstrate that the recommended or requested health care
6 service or treatment is more likely than any available standard
7 health care service or treatment to be beneficial to the covered
8 person and the adverse risks would not be substantially increased
9 over those of available standard health care services or treatments.
10 (3) A clinical reviewer shall include the following in his or her
11 written opinion to the certified independent review organization:
12 (a) A description of the covered person's medical condition;
13 (b) A description of the indicators relevant to determining
14 whether there is sufficient evidence to demonstrate that the
15 recommended or requested health care service or treatment is likely
16 to be more beneficial to the covered person than any available
17 standard health care services or treatments and the adverse risks
18 would not be substantially increased over those of available standard
19 health care services or treatments;
20 (c) A description and analysis of any medical, scientific, or
21 cost-effectiveness evidence, as defined in rule;
22 (d) A description and analysis of any evidence-based standard, as
23 defined in rule; and
24 (e) Information on whether the clinical reviewer's rationale for
25 the opinion is based on subsection (2)(d) or (e) of this section.
26 (4) A certified independent review organization shall include the
27 following in the notification of the results and rationale for the
28 determination:
29 (a) A general description of the reason for the request for
30 external review;
31 (b) The written opinion of each clinical reviewer, including
32 whether the recommended or requested health care service or treatment
33 should be covered and the rationale for each reviewer's
34 recommendation;
35 (c) The date the external review was requested, the date the
36 external review was conducted, and the date of the certified
37 independent review organization's determination; and
38 (d) The principal reason or reasons and the rationale for the
39 certified independent review organization's determination.

NEW SECTION. **Sec. 6.** (1) A certified independent review organization shall notify the covered person and the issuer of the result and rationale for the determination within the time frame in subsection (6) of this section. The notification must include the clinical basis for the determination unless the determination is wholly based on application of coverage provisions. Notification of the determination must be provided initially by telephone, email, or facsimile, followed by a written report by mail. In the case of expedited external reviews the initial notification must be immediate and by telephone.

(2) Documentation of the basis for the determination must include references to supporting evidence, and if applicable, the rationale for any interpretation regarding the application of health plan coverage provisions.

(3) If the determination overrides the health plan's medical necessity or appropriateness standards, the rationale must document why the health plan's standards are unreasonable or inconsistent with sound, evidence-based medical practice.

(4) The written report must include the qualifications of the reviewers but may not disclose the identity of the reviewers.

(5) The independent review process is intended to be neutral and independent of influence by any affected party or by state government. The insurance commissioner may conduct investigations under the provisions of this chapter but the insurance commissioner has no involvement in the disposition of specific cases.

(6)(a) Except as provided in (b) and (c) of this subsection, the certified independent review organization shall make its determination no later than the earlier of: (i) The fifteenth day after the date the certified independent review organization receives all information necessary to make the determination; or (ii) the twentieth day after the date the certified independent review organization receives the request that the determination be made.

(b) In exceptional circumstances when information is incomplete, a determination may be made by the twenty-fifth day after the date the certified independent review organization received the request for the determination.

(c) In requests for expedited review under section 3 of this act, the certified independent review organization shall make the determination as expeditiously as possible but not more than seventy-

1 two hours after the date it receives the request for expedited
2 external review.

3 NEW SECTION. **Sec. 7.** (1) A certified independent review
4 organization's determination is final and binding on the issuer. An
5 issuer shall promptly implement the certified independent review
6 organization's determination and pay the certified independent review
7 organization's charges.
8 (2) The commissioner shall develop a reasonable maximum fee
9 schedule that certified independent review organizations must use to
10 assess issuers for conducting external reviews authorized under this
11 chapter.

12 NEW SECTION. **Sec. 8.** (1) An issuer shall submit all redacted
13 independent review organization determinations to the commissioner
14 after removing the names of the parties, including, but not limited
15 to, the covered person, medical providers, and names of the issuer's
16 employees or contractors.
17 (2) Each certified independent review organization shall provide
18 the commissioner with an annual statistical summary report of the
19 external reviews conducted during the calendar year, along with the
20 results of the reviews. The commissioner may develop a form for the
21 annual statistical summary report.
22 (a) The report must include the following information, as well as
23 any information required by rule:
24 (i) The total number of requests for external review, in the
25 aggregate and by issuer;
26 (ii) The number of requests for external review resolved, the
27 number resolved upholding the adverse benefit determination or final
28 adverse benefit determination, and the number resolved reversing the
29 adverse benefit determination or final adverse benefit determination,
30 in the aggregate and by issuer;
31 (iii) The number of requests for standard external reviews and
32 the number of requests for expedited external reviews, in the
33 aggregate and by issuer;
34 (iv) The number of requests for external review that involved
35 medical necessity, experimental or investigational treatments, or
36 contractual coverage disputes, in the aggregate and by issuer;

1 (v) The independent review organization's compliance with
2 determination and notification deadlines for expedited and standard
3 reviews;
4 (vi) The number and nature of complaints regarding the
5 independent review organization; and
6 (vii) The independent review organization's compliance with
7 conflict of interest requirements.
8 (b) The information required by (a)(i) through (iv) of this
9 subsection must be provided in the aggregate, by issuer, and by the
10 covered person's ethnicity, race, and primary language spoken.
11 (3) The commissioner shall make all redacted determinations and
12 statistical summary reports available to the public in a database on
13 the commissioner's internet web site, taking into consideration laws
14 governing disclosure of public records, confidentiality, and personal
15 privacy. Information for independent review determinations in the
16 database must include and be searchable by the following:
17 (a) Covered person demographic profile information, including age
18 and gender;
19 (b) Covered person diagnosis or condition and disputed health
20 care service;
21 (c) Name of the issuer;
22 (d) Whether the independent review was for medically necessary
23 services, experimental or investigational treatments, or a
24 contractual coverage dispute;
25 (e) Whether the external review was standard or expedited;
26 (f) Length of time from the certified independent review
27 organization's receipt of a request for external review and
28 supporting documentation until the certified independent review
29 organization notified the covered person of its determination;
30 (g) The credentials and qualifications of the reviewer or
31 reviewers;
32 (h) The nature of the criteria that the reviewer or reviewers
33 used to make the determination;
34 (i) The final result of the determination and the date the
35 determination was made;
36 (j) A detailed case summary that includes the specific standards,
37 criteria, and medical and scientific evidence, if any, that led to
38 the determination; and

1 (k) If the covered person was limited English proficient, whether
2 the independent review organization's notices and determinations were
3 translated and provided to the covered person in a timely manner.

4 NEW SECTION. **Sec. 9.** A certified independent review
5 organization shall notify the commissioner if, based upon the
6 external reviews it performs under this chapter, it observes a
7 pattern of substandard or egregious conduct by an issuer.

8 NEW SECTION. **Sec. 10.** (1) The commissioner shall adopt rules
9 providing a procedure and criteria for certifying one or more
10 organizations to perform external reviews under this chapter.
11 (2) The rules must require that the independent review
12 organization ensure:
13 (a) The confidentiality of medical records transmitted to the
14 organization for use in external reviews;
15 (b) That each health care provider, physician, or contract
16 specialist making external review determinations is qualified.
17 Physicians, other health care providers, and, if applicable, contract
18 specialists must be appropriately licensed, certified, or registered
19 as required in this state or in at least one state with standards
20 substantially equivalent to this state. Reviewers may be drawn from
21 nationally recognized centers of excellence, academic institutions,
22 and recognized leading practice sites. Expert clinical reviewers
23 should have substantial, recent clinical experience dealing with the
24 same or similar health conditions, treatments, or services. For
25 experimental or investigational treatment reviews, in addition to any
26 other qualifications for reviewers, at least part of the clinical
27 reviewers' relevant, recent clinical experience must have been
28 obtained in the past three years. The organization must have
29 demonstrated expertise and a history of reviewing health care in
30 terms of medical necessity, appropriateness, the application of other
31 health plan coverage provisions, and experimental or investigational
32 treatments;
33 (c) That any physician, health care provider, or contract
34 specialist making a determination in a specific external review is
35 free of any actual or potential conflict of interest or bias. Neither
36 the expert reviewer, nor the independent review organization, nor any
37 officer, director, or management employee of the independent review
38 organization may have any material professional, familial, or

financial affiliation with any of the following: The issuer; professional associations of issuers and providers; the provider; the provider's medical or practice group; the health facility at which the service would be provided; the developer or manufacturer of a drug or device under review; or the covered person;

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

(e) That the independent review organization has a quality assurance mechanism in place that ensures the timeliness and quality of review and communication of determinations to covered persons and issuers, and the qualifications, impartiality, and freedom from conflict of interest of the organization, its staff, and expert reviewers; and

(f) That the independent review organization meets any other reasonable requirements of the commissioner directly related to the functions the organization is to perform under this chapter, and related to assessing fees to issuers in a manner consistent with the maximum fee schedule developed under section 7 of this act.

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

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

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

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

(d) The name and a biographical sketch of each director, officer, and executive of the applicant and any entity listed under (c) of this subsection and a description of any relationship the named individual has with: (i) An issuer; (ii) a utilization review agent; (iii) a nonprofit or for-profit health corporation; (iv) a health care provider; (v) a drug or device manufacturer; or (vi) a group representing any of the entities described by (d)(i) through (v) of this subsection;

1 (e) The percentage of the applicant's revenues that are
2 anticipated to be derived from external reviews conducted under this
3 chapter;
4 (f) A description of the areas of expertise of the health care
5 professionals and contract specialists making determinations for the
6 applicant; and
7 (g) The procedures to be used by the independent review
8 organization in making determinations under this chapter.
9 (4) If at any time there is a material change in the information
10 included in the application under subsection (3) of this section, the
11 certified independent review organization shall submit updated
12 information to the commissioner.
13 (5) A certified independent review organization may not be a
14 subsidiary of, or in any way owned or controlled by, an issuer or a
15 trade or professional association of health care providers or
16 issuers.
17 (6) In adopting rules under this section, the commissioner shall
18 take into consideration standards for independent review
19 organizations adopted by national accreditation organizations. The
20 commissioner may accept national accreditation or certification by
21 another state as evidence that an organization satisfies some or all
22 of the requirements for certification by the commissioner as an
23 independent review organization.

24 NEW SECTION. **Sec. 11.** The commissioner shall establish and use
25 a rotational registry system for the assignment of a certified
26 independent review organization to each external review. The system
27 should be flexible enough to ensure that the certified independent
28 review organization has the expertise necessary to review the
29 particular medical condition, treatment, or service at issue in the
30 external review and that the certified independent review
31 organization does not have a conflict of interest that will influence
32 its independence.

33 NEW SECTION. **Sec. 12.** Each certified independent review
34 organization shall:
35 (1) Maintain written and electronic records and make them
36 available upon request to the commissioner. These records must
37 include determinations, as well as the information required to be
38 submitted to the commissioner under section 8 of this act; and

(2) Conduct an annual self-assessment of compliance with the requirements of this chapter or rules adopted under this chapter, including but not limited to certification and determination requirements.

<u>NEW SECTION.</u> **Sec. 13.** (1) The commissioner may review the operation and performance of a certified independent review organization in response to complaints or other concerns about compliance.

(2) The commissioner may deny, suspend, revoke, or modify certification of an independent review organization if the commissioner has reason to believe the applicant, certified independent review organization, or the certified independent review organization's officers, directors, or management employees have failed to comply with the requirements in this chapter or rules adopted by the commissioner.

<u>NEW SECTION.</u> **Sec. 14.** A certified independent review organization, clinical reviewer working on behalf of a certified independent review organization, or an employee, agent, or contractor of a certified independent review organization is not liable in damages to any person for opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

<u>NEW SECTION.</u> **Sec. 15.** (1) The commissioner shall adopt rules to implement this chapter, taking into consideration relevant standards adopted by national managed care accreditation organizations and the national association of insurance commissioners.

(2) This chapter does not supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce issuer compliance with applicable statutes and rules.

Sec. 16. RCW 41.05.017 and 2008 c 304 s 2 are each amended to read as follows:

Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not

subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through ((~~48.43.535~~)) 48.43.530, ((~~43.70.235,~~)) 48.43.545, 48.43.550, 70.02.110, 70.02.900, 48.43.190, ((~~and~~)) 48.43.083, and chapter 48.-- RCW (the new chapter created in section 23 of this act).

Sec. 17. RCW 48.43.005 and 2012 c 211 s 17 and 2012 c 87 s 1 are each reenacted and amended to read as follows:

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

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

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

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

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

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

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

(7) "Board" means the governing board of the Washington health benefit exchange established in chapter 43.71 RCW.

(8)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

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

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

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

(9) "Certification" means a determination by a review organization that an admission, extension of stay, or other health

care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

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

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

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

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

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

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

(16) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care

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

(17) "Exchange" means the Washington health benefit exchange established under chapter 43.71 RCW.

(18) ((~~"Final external review decision" means a determination by an independent review organization at the conclusion of an external review.~~

~~(19) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.~~

~~(20)~~)) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

((~~(21)~~)) (19) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

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

((~~(23)~~)) (21) "Health care provider" or "provider" means:

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

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

((~~(24)~~)) (22) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(25)~~)) (23) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

((~~(26)~~)) (24) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that

is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(27)~~)) (25) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

((~~(28)~~)) (26) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(29)~~)) (27) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

((~~(30)~~)) (28) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(31)~~)) (29) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

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

((~~(33)~~)) (31) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the

1 number of employees, companies that are affiliated companies, or that
2 are eligible to file a combined tax return for purposes of taxation
3 by this state, shall be considered an employer. Subsequent to the
4 issuance of a health plan to a small employer and for the purpose of
5 determining eligibility, the size of a small employer shall be
6 determined annually. Except as otherwise specifically provided, a
7 small employer shall continue to be considered a small employer until
8 the plan anniversary following the date the small employer no longer
9 meets the requirements of this definition. A self-employed individual
10 or sole proprietor who is covered as a group of one must also: (a)
11 Have been employed by the same small employer or small group for at
12 least twelve months prior to application for small group coverage,
13 and (b) verify that he or she derived at least seventy-five percent
14 of his or her income from a trade or business through which the
15 individual or sole proprietor has attempted to earn taxable income
16 and for which he or she has filed the appropriate internal revenue
17 service form 1040, schedule C or F, for the previous taxable year,
18 except a self-employed individual or sole proprietor in an
19 agricultural trade or business, must have derived at least fifty-one
20 percent of his or her income from the trade or business through which
21 the individual or sole proprietor has attempted to earn taxable
22 income and for which he or she has filed the appropriate internal
23 revenue service form 1040, for the previous taxable year.

24 ((~~(34)~~)) (32) "Special enrollment" means a defined period of time
25 of not less than thirty-one days, triggered by a specific qualifying
26 event experienced by the applicant, during which applicants may
27 enroll in the carrier's individual health benefit plan without being
28 subject to health screening or otherwise required to provide evidence
29 of insurability as a condition for enrollment.

30 ((~~(35)~~)) (33) "Standard health questionnaire" means the standard
31 health questionnaire designated under chapter 48.41 RCW.

32 ((~~(36)~~)) (34) "Utilization review" means the prospective,
33 concurrent, or retrospective assessment of the necessity and
34 appropriateness of the allocation of health care resources and
35 services of a provider or facility, given or proposed to be given to
36 an enrollee or group of enrollees.

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

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

Sec. 18. RCW 48.43.530 and 2012 c 211 s 20 are each amended to read as follows:

(1) Each carrier and health plan must have fully operational, comprehensive grievance and appeal processes, and for plans that are not grandfathered, fully operational, comprehensive, and effective grievance and review of adverse benefit determination processes that comply with the requirements of this section and any rules adopted by the commissioner to implement this section. For the purposes of this section, the commissioner must consider applicable grievance and appeal or review of adverse benefit determination process standards adopted by national managed care accreditation organizations and state agencies that purchase managed health care services, and for health plans that are not grandfathered health plans as approved by the United States department of health and human services or the United States department of labor. In the case of coverage offered in connection with a group health plan, if either the carrier or the health plan complies with the requirements of this section and ((~~RCW 48.43.535~~)) chapter 48.-- RCW (the new chapter created in section 23 of this act), then the obligation to comply is satisfied for both the carrier and the plan with respect to the health insurance coverage.

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

(3) Each carrier and health plan must provide written notice to an enrollee or the enrollee's designated representative, and the enrollee's provider, of its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a health care facility.

(4) An enrollee's written or oral request that a carrier reconsider its decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility must be processed as follows:

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

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

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

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

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

(b) Assist the enrollee with the appeal process;

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

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

(e) Consider information submitted by the enrollee;

(f) Investigate and resolve the appeal; and

(g) Provide written notice of its resolution of the appeal to the enrollee and, with the permission of the enrollee, to the enrollee's providers. The written notice must explain the carrier's and health plan's decision and the supporting coverage or clinical reasons and the enrollee's right to request independent review of the carrier's decision under ((~~RCW 48.43.535~~)) chapter 48.-- RCW (the new chapter created in section 23 of this act).

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

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

(b) The carrier's and grandfathered plan's appeal or for plans that are not grandfathered, adverse benefit determination review process, including information, as appropriate, about how to exercise

the enrollee's rights to obtain a second opinion, and how to continue receiving services as provided in this section.

(7) When an enrollee requests that the carrier or health plan reconsider its decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving through the health plan and the carrier's or health plan's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier and health plan must continue to provide that health service until the appeal, or for health plans that are not grandfathered, the review of an adverse benefit determination, is resolved. If the resolution of the appeal, review of an adverse benefit determination, or any review sought by the enrollee under ((~~RCW 48.43.535~~)) chapter 48.-- RCW (the new chapter created in section 23 of this act) affirms the carrier's or health plan's decision, the enrollee may be responsible for the cost of this continued health service.

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

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

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

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

(11) In complying with this section, plans that are not grandfathered and the carriers offering them must treat a rescission

1 of coverage, whether or not the rescission has an adverse effect on
2 any particular benefit at that time, and any decision to deny
3 coverage in an initial eligibility determination as an adverse
4 benefit determination.

5 **Sec. 19.** RCW 48.43.545 and 2000 c 5 s 17 are each amended to
6 read as follows:

7 (1)(a) A health carrier shall adhere to the accepted standard of
8 care for health care providers under chapter 7.70 RCW when arranging
9 for the provision of medically necessary health care services to its
10 enrollees. A health carrier shall be liable for any and all harm
11 proximately caused by its failure to follow that standard of care
12 when the failure resulted in the denial, delay, or modification of
13 the health care service recommended for, or furnished to, an
14 enrollee.

15 (b) A health carrier is also liable for damages under (a) of this
16 subsection for harm to an enrollee proximately caused by health care
17 treatment decisions that result from a failure to follow the accepted
18 standard of care made by its:

19 (i) Employees;

20 (ii) Agents; or

21 (iii) Ostensible agents who are acting on its behalf and over
22 whom it has the right to exercise influence or control or has
23 actually exercised influence or control.

24 (2) The provisions of this section may not be waived, shifted, or
25 modified by contract or agreement and responsibility for the
26 provisions shall be a duty that cannot be delegated. Any effort to
27 waive, modify, delegate, or shift liability for a breach of the duty
28 established by this section, through a contract for indemnification
29 or otherwise, is invalid.

30 (3) This section does not create any new cause of action, or
31 eliminate any presently existing cause of action, with respect to
32 health care providers and health care facilities that are included in
33 and subject to the provisions of chapter 7.70 RCW.

34 (4) It is a defense to any action or liability asserted under
35 this section against a health carrier that:

36 (a) The health care service in question is not a benefit provided
37 under the plan or the service is subject to limitations under the
38 plan that have been exhausted;

(b) Neither the health carrier, nor any employee, agent, or ostensible agent for whose conduct the health carrier is liable under subsection (1)(b) of this section, controlled, influenced, or participated in the health care decision; or

(c) The health carrier did not deny or unreasonably delay payment for treatment prescribed or recommended by a participating health care provider for the enrollee.

(5) This section does not create any liability on the part of an employer, an employer group purchasing organization that purchases coverage or assumes risk on behalf of its employers, or a governmental agency that purchases coverage on behalf of individuals and families. The governmental entity established to offer and provide health insurance to public employees, public retirees, and their covered dependents under RCW 41.05.140 is subject to liability under this section.

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

(7)(a) A person may not maintain a cause of action under this section against a health carrier unless:

(i) The affected enrollee has suffered substantial harm. As used in this subsection, "substantial harm" means loss of life, loss or significant impairment of limb, bodily or cognitive function, significant disfigurement, or severe or chronic physical pain; and

(ii) The affected enrollee or the enrollee's representative has exercised the opportunity established in ((~~RCW 48.43.535~~)) chapter 48.-- RCW (the new chapter created in section 23 of this act) to seek ((~~independent~~)) external review of the health care treatment decision.

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

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

(9) Any action under this section shall be commenced within three years of the completion of the independent review process.

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

Sec. 20. RCW 48.125.030 and 2008 c 217 s 96 are each amended to read as follows:

The commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the satisfaction of the commissioner that the following requirements have been satisfied by the arrangement:

(1) The employers participating in the arrangement are members of a bona fide association;

(2) The employers participating in the arrangement exercise control over the arrangement, as follows:

(a) Subject to (b) of this subsection, control exists if the board of directors of the bona fide association or the employers participating in the arrangement have the right to elect at least seventy-five percent of the individuals designated in the arrangement's organizational documents as having control over the operations of the arrangement and the individuals designated in the arrangement's organizational documents in fact exercise control over the operation of the arrangement; and

(b) The use of a third-party administrator to process claims and to assist in the administration of the arrangement is not evidence of the lack of exercise of control over the operation of the arrangement;

(3) In this state, the arrangement provides only health care services;

(4) In this state, the arrangement provides or arranges benefits for health care services in compliance with those provisions of this title that mandate particular benefits or offerings and with provisions that require access to particular types or categories of health care providers and facilities;

(5) In this state, the arrangement provides or arranges benefits for health care services in compliance with RCW 48.43.500 through ((~~48.43.535,~~)) 48.43.545, ((~~and~~)) 48.43.550, and chapter 48.-- RCW (the new chapter created in section 23 of this act);

(6) The arrangement provides health care services to not less than twenty employers and not less than seventy-five employees;

(7) The arrangement may not solicit participation in the arrangement from the general public. However, the arrangement may employ licensed insurance producers who receive a commission, unlicensed individuals who do not receive a commission, and may contract with a licensed insurance producer who may be paid a commission or other remuneration, for the purpose of enrolling and renewing the enrollments of employers in the arrangement;

(8) The arrangement has been in existence and operated actively for a continuous period of not less than ten years as of December 31, 2003, except for an arrangement that has been in existence and operated actively since December 31, 2000, and is sponsored by an association that has been in existence more than twenty-five years; and

(9) The arrangement is not organized or maintained solely as a conduit for the collection of premiums and the forwarding of premiums to an insurance company.

Sec. 21. RCW 70.47.130 and 2009 c 298 s 4 are each amended to read as follows:

(1) The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW except:

(a) Benefits as provided in RCW 70.47.070;

(b) Managed health care systems are subject to the provisions of RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through ((~~48.43.535~~)) 48.43.530, ((~~43.70.235,~~)) 48.43.545, 48.43.550, 70.02.110, ((~~and~~)) 70.02.900, and chapter 48.-- RCW (the new chapter created in section 23 of this act);

(c) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection (1)(c), "solicit" does not include distributing information and applications for the basic health plan and responding to questions;

(d) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201; and

1 (e) Administrative simplification requirements as provided in
2 chapter 298, Laws of 2009.
3 (2) The purpose of the 1994 amendatory language to this section
4 in chapter 309, Laws of 1994 is to clarify the intent of the
5 legislature that premiums paid on behalf of nonsubsidized enrollees
6 in the basic health plan are subject to the premium and prepayment
7 tax. The legislature does not consider this clarifying language to
8 either raise existing taxes nor to impose a tax that did not exist
9 previously.

10 NEW SECTION. **Sec. 22.** The following acts or parts of acts are
11 each repealed:
12 (1) RCW 43.70.235 (Health care disputes—Certifying independent
13 review organizations—Application—Restrictions—Maximum fee schedule
14 for conducting reviews—Rules) and 2012 c 211 s 14, 2005 c 54 s 1, &
15 2000 c 5 s 12; and
16 (2) RCW 48.43.535 (Independent review of health care disputes—
17 System for using certified independent review organizations—Rules)
18 and 2012 c 211 s 21, 2011 c 314 s 5, & 2000 c 5 s 11.

19 NEW SECTION. **Sec. 23.** Sections 1 through 15 of this act
20 constitute a new chapter in Title 48 RCW.

21 NEW SECTION. **Sec. 24.** This act takes effect January 1, 2017.

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