Z-0936.2

SENATE BILL 6181

State of Washington 62nd Legislature 2012 Regular Session

By Senators Keiser, Benton, and Hobbs; by request of Insurance Commissioner

Read first time 01/13/12. Referred to Committee on Financial Institutions, Housing & Insurance.

AN ACT Relating to insurers and insurance products; amending RCW 4.28.080, 48.05.440, 48.06.040, 48.17.010, 48.38.010, 48.38.020, 48.38.050, 48.43.310, 48.85.010, 48.85.020, 48.125.050, 48.17.380, 43.70.235, 48.20.435, 48.43.018, 48.44.215, 48.46.325, 48.43.530, 48.43.535, 48.46.030, 48.46.040, 48.41.110, and 48.43.510; reenacting and amending RCW 48.43.005 and 48.46.020; and repealing RCW 48.19.450.

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

Sec. 1. RCW 4.28.080 and 2011 c 47 s 1 are each amended to read as follows:

Service made in the modes provided in this section is personal service. The summons shall be served by delivering a copy thereof, as follows:

(1) If the action is against any county in this state, to the county auditor or, during normal office hours, to the deputy auditor, or in the case of a charter county, summons may be served upon the agent, if any, designated by the legislative authority.

(2) If against any town or incorporated city in the state, to the mayor, city manager, or, during normal office hours, to the mayor's or city manager's designated agent or the city clerk thereof.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

To apply for a solicitation permit the person shall:

(1) File with the commissioner a request showing:

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

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

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

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

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

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

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

(2) File with the commissioner:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) Which:

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

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

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

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

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

(2) The assets of the separate reserve fund:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The RBC plan shall be submitted:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Is eighteen or more years of age;

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

(c) Is a trustworthy person;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) That any physician, health care provider, or contract specialist making a review determination in a specific review is free of any actual or potential conflict of interest or bias. Neither the expert reviewer, nor the independent review organization, nor any officer, director, or management employee of the independent review organization may have any material professional, familial, or financial affiliation with any of the following: The health carrier; professional associations of carriers 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 enrollee;

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

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

(i) Not later than the earlier of:

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

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

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

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

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

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

(g) 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 enrollees and carriers, and the qualifications, impartiality, and freedom from conflict of interest of the organization, its staff, and expert reviewers; and

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

(3) To be certified as an independent review organization under this chapter, an organization must submit to the department an application in the form required by the department. 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) A carrier;

(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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) If the person applying for an individual health benefit plan: (a) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (b) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health

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

Sec. 17. RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 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) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand 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

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand 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; or

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

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. The adjusted amount shall apply on the following January 1st.

(8) "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.

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

(10) "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.

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

(12) "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.

(13) "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)).

(14) "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.

(15) "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.

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

(17) "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.

(18) "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.

(19) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding((~~: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b)~~)) 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.

(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.

(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.

(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.

(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).

(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.

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

(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.

((~~(26)~~)) (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.

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

((~~(28)~~)) (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.

((~~(29)~~)) (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.

((~~(30)~~)) (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 number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

((~~(31)~~)) (32) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the 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.

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

((~~(33)~~)) (34) "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 an enrollee or group of enrollees.

((~~(34)~~)) (35) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of 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 48.44.215 and 2011 c 314 s 6 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

(1) Each carrier ((~~that offers a~~)) and health plan must have ((~~a~~)) fully operational, comprehensive grievance ((~~process that complies~~)) 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 ((~~shall~~)) 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, 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 ((~~complaint~~)) 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 ((~~complaints~~)) 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) ((~~Each carrier must process as an appeal an enrollee's written or oral request that the carrier reconsider: (a) Its resolution of a complaint made by an enrollee; or (b) 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. A carrier must not require that an enrollee file a complaint prior to seeking appeal of a decision under (b) of this subsection.~~)) 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier'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 must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

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

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

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

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

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

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

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

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

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

(3) "Commissioner" means the insurance commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(c)~~)) Any arrangements for liability and malpractice insurance coverage; and

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

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

(5) Procedures have been established to:

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not less than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery including at least the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

(o) Services of a physical therapist and services of a speech therapist;

(p) Hospice services;

(q) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury;

(r) Mental health services pursuant to RCW 48.41.220; and

(s) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition.

(5) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

(6) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

--- END ---