RCW 48.43.005 Definitions. 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) "Air ambulance service" has the same meaning as defined in section 2799A-2 of the public health service act (42 U.S.C. Sec. 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(4) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(5) "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.

(6) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

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

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

(9) "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.

(10) "Behavioral health emergency services provider" means emergency services provided in the following settings:

(a) A crisis stabilization unit as defined in RCW 71.05.020;

(b) A 23-hour crisis relief center as defined in RCW 71.24.025;

(c) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(d) An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;

(e) An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or

(f) A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.

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

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

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, $1,750 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least $3,500, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, $3,500 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least $6,000, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding 12 months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

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

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

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

(13) "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.

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

(15) "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.

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

(17) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment 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.

(18) "Emergency services" means:

(a)(i) A medical screening examination, as required under section 1867 of the social security act (42 U.S.C. Sec. 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;

(ii) 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. Sec. 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. Sec. 1395dd(e)(3)); and

(iii) Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

(b)(i) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;

(ii) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, 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. Sec. 1395dd(e)(3)); and

(iii) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(19) "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.

(20) "Enrollee point-of-service cost-sharing" or "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.

(21) "Essential health benefit categories" means:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management; and

(j) Pediatric services, including oral and vision care.

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

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

(24) "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.

(25) "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.

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

(27) "Ground ambulance services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose; and

(b) Ground ambulance transport between hospitals or behavioral health emergency services providers, hospitals or behavioral health emergency services providers and other health care facilities or locations, and between health care facilities when the services are

medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose.

(28) "Ground ambulance services organization" means a public or private organization licensed by the department of health under chapter 18.73 RCW to provide ground ambulance services. For purposes of this chapter, ground ambulance services organizations are not considered providers.

(29) "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, behavioral health 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 or 70.230 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.

(30) "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.

(31) "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.

(32) "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).

(33) "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;

(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;

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA);

(n) Stand-alone prescription drug coverage that exclusively supplements medicare part D coverage provided through an employer group waiver plan under federal social security act regulation 42 C.F.R. Sec. 423.458(c); and

(o) Beginning January 1, 2027, travel insurance as defined in RCW 48.216.020.

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

(35) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations.

(36) "Local governmental entity" means any entity that is authorized to establish or provide ground ambulance services or set rates for ground ambulance services, including those as authorized in RCW 35.27.370, 35.23.456, 52.12.135, chapter 35.21 RCW, or as authorized under any state law.

(37) "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.

(38) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" means covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as in effect on March 31, 2022.

(39) "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.

(40) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(41) "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

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

(43) "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.

(44)(a) "Protected individual" means:

(i) An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or

(ii) A minor who may obtain health care without the consent of a parent or legal guardian, pursuant to state or federal law.

(b) "Protected individual" does not include an individual deemed not competent to provide informed consent for care under **RCW 11.88.010(1)(e).

(45) "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.

(46) "Sensitive health care services" means health services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender-affirming care, domestic violence, and mental health.

(47) "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 50 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 75 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 51 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.

(48) "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.

(49) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(50) "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.

(51) "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. [2026 c 165 s 14; 2024 c 218 s 1; 2023 c 433 s 20. Prior: 2022 c 263 s 2; 2020 c 196 s 1; prior: 2019 c 427 s 2; 2019 c 56 s 2; 2019 c 33 s 1; 2016 c 65 s 2; prior: 2012 c 211 s 17; 2012 c 87 s 1; prior: 2011 c 315 s 2; 2011 c 314 s 3; prior: 2010 c 292 s 1; prior: 2008 c 145 s 20; 2008 c 144 s 1; prior: 2007 c 296 s 1; 2007 c 259 s 32; 2006 c 25 s 16; 2004 c 244 s 2; prior: 2001 c 196 s 5; 2001 c 147 s 1; 2000 c 79 s 18; prior: 1997 c 231 s 202; 1997 c 55 s 1; 1995 c 265 s 4.]

Reviser's note: *(1) Chapter 70.96A RCW was repealed and/or recodified in its entirety pursuant to 2016 sp.s. c 29 ss 301, 601, and 701.

**(2) RCW 11.88.010 was repealed by 2020 c 312 s 904, effective January 1, 2022.

Effective date—2022 c 263: See note following RCW 43.371.100.

Effective date—2020 c 196: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 27, 2020]." [2020 c 196 s 2.]

Findings—Intent—Effective date—2019 c 427: See RCW 48.49.003 and 48.49.900.

Findings—Declarations—Effective date—2019 c 56: See notes following RCW 48.43.5051.

Effective date—2019 c 33: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 17, 2019]." [2019 c 33 s 17.]

Spiritual care services—2012 c 87: See RCW 43.71.901.

Intent—2011 c 315: "The federal patient protection and affordable care act (P.L. 111-148) prohibits insurance carriers from applying preexisting condition limitations for persons under age nineteen, beginning on or after September 23, 2010. The guidance from the United States department of health and human services provides some direction for the implementation of the new policy requirement, and the office of the insurance commissioner further clarified open enrollment requirements to help prevent disruption in the individual health insurance marketplace. It is the intent of this act to:

(1) Maintain access to individual plan options for persons under age nineteen; and

(2) Provide clarity for the establishment of open enrollment and special open enrollment periods that balance access to guaranteed issue coverage with efforts that protect market stability." [2011 c 315 s 1.]

Application—2010 c 292: "This act applies to policies issued or renewed on or after January 1, 2011." [2010 c 292 s 9.]

Contingent effective date—2010 c 292 ss 1 and 2: "Sections 1 and 2 of this act take effect one hundred eighty days [September 29, 2010] after the date the insurance commissioner certifies to the secretary of the senate, the chief clerk of the house of representatives, and the code reviser's office that federal legislation has been signed into law by the President of the United States that includes guaranteed issue for individuals who purchase health coverage through the individual or small group markets." [2010 c 292 s 11.]

Effective date—2008 c 145: See RCW 48.83.901.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—2001 c 196: See note following RCW 48.20.025.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Short title—1997 c 231: "This act shall be known as the consumer assistance and insurance market stabilization act." [1997 c 231 s 402.]

Part headings and captions not law—1997 c 231: "Part headings and section captions used in this act are not part of the law." [1997 c 231 s 403.]

Severability—1997 c 231: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1997 c 231 s 404.]

Effective dates—1997 c 231: "(1) Sections 104 through 108 and 301 of this act take effect January 1, 1998.

(2) Section 111 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the

state government and its existing public institutions, and takes effect July 1, 1997.

(3) Section 205 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately." [1997 c 231 s 405.]

Effective date—1997 c 55: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 16, 1997]." [1997 c 55 s 2.]

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.