

CERTIFICATION OF ENROLLMENT  
**ENGROSSED SUBSTITUTE SENATE BILL 5122**

62nd Legislature  
2011 Regular Session

Passed by the Senate April 14, 2011  
YEAS 44 NAYS 2

---

**President of the Senate**

Passed by the House April 9, 2011  
YEAS 63 NAYS 32

---

**Speaker of the House of Representatives**

Approved

---

**Governor of the State of Washington**

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5122** as passed by the Senate and the House of Representatives on the dates hereon set forth.

---

**Secretary**

FILED

**Secretary of State  
State of Washington**

---

**ENGROSSED SUBSTITUTE SENATE BILL 5122**

---

AS AMENDED BY THE HOUSE

Passed Legislature - 2011 Regular Session

**State of Washington                      62nd Legislature                      2011 Regular Session**

**By** Senate Health & Long-Term Care (originally sponsored by Senators Keiser and Kline; by request of Insurance Commissioner)

READ FIRST TIME 02/08/11.

1            AN ACT Relating to changes for implementation of the affordable  
2 care act in Washington state; amending RCW 48.20.435, 48.21.270,  
3 48.43.530, 48.43.535, 48.44.215, 48.44.380, 48.46.325, 48.46.460,  
4 48.20.025, 48.44.017, 48.46.062, 48.41.060, 48.41.080, 48.41.100,  
5 48.41.140, and 48.21.157; reenacting and amending RCW 48.43.005; adding  
6 a new section to chapter 48.43 RCW; and providing an effective date.

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

8            **Sec. 1.** RCW 48.20.435 and 2007 c 259 s 19 are each amended to read  
9 as follows:

10            Any disability insurance contract that provides coverage for a  
11 subscriber's dependent must offer the option of covering any  
12 (~~unmarried~~) dependent under the age of (~~twenty-five~~) twenty-six.

13            **Sec. 2.** RCW 48.21.270 and 1984 c 190 s 4 are each amended to read  
14 as follows:

15            (1) An insurer shall not require proof of insurability as a  
16 condition for issuance of the conversion policy.

17            (2) A conversion policy may not contain an exclusion for  
18 preexisting conditions (~~except~~) for any applicant who is under age

1 nineteen. For policies issued to those age nineteen and older, an  
2 exclusion for a preexisting condition is permitted only to the extent  
3 that a waiting period for a preexisting condition has not been  
4 satisfied under the group policy.

5 (3) An insurer must offer at least three policy benefit plans that  
6 comply with the following:

7 (a) A major medical plan with a five thousand dollar deductible  
8 ~~((and a lifetime benefit maximum of two hundred fifty thousand~~  
9 ~~dollars))~~ per person;

10 (b) A comprehensive medical plan with a five hundred dollar  
11 deductible ~~((and a lifetime benefit maximum of five hundred thousand~~  
12 ~~dollars))~~ per person; and

13 (c) A basic medical plan with a one thousand dollar deductible  
14 ~~((and a lifetime maximum of seventy five thousand dollars))~~ per person.

15 (4) The insurance commissioner may revise the ~~((deductibles and~~  
16 ~~lifetime benefit))~~ deductible amounts in subsection (3) of this section  
17 from time to time to reflect changing health care costs.

18 (5) The insurance commissioner shall adopt rules to establish  
19 minimum benefit standards for conversion policies.

20 (6) The commissioner shall adopt rules to establish specific  
21 standards for conversion policy provisions. These rules may include  
22 but are not limited to:

23 (a) Terms of renewability;

24 (b) Nonduplication of coverage;

25 (c) Benefit limitations, exceptions, and reductions; and

26 (d) Definitions of terms.

27 **Sec. 3.** RCW 48.43.005 and 2010 c 292 s 1 are each reenacted and  
28 amended to read as follows:

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

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

35 (2) "Adverse benefit determination" means a denial, reduction, or  
36 termination of, or a failure to provide or make payment, in whole or in  
37 part, for a benefit, including a denial, reduction, termination, or

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

10 (3) "Basic health plan" means the plan described under chapter  
11 70.47 RCW, as revised from time to time.

12 ((+3)) (4) "Basic health plan model plan" means a health plan as  
13 required in RCW 70.47.060(2)(e).

14 ((+4)) (5) "Basic health plan services" means that schedule of  
15 covered health services, including the description of how those  
16 benefits are to be administered, that are required to be delivered to  
17 an enrollee under the basic health plan, as revised from time to time.

18 ((+5)) (6) "Catastrophic health plan" means:

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

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

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

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

8 ~~((+6))~~ (7) "Certification" means a determination by a review  
9 organization that an admission, extension of stay, or other health care  
10 service or procedure has been reviewed and, based on the information  
11 provided, meets the clinical requirements for medical necessity,  
12 appropriateness, level of care, or effectiveness under the auspices of  
13 the applicable health benefit plan.

14 ~~((+7))~~ (8) "Concurrent review" means utilization review conducted  
15 during a patient's hospital stay or course of treatment.

16 ~~((+8))~~ (9) "Covered person" or "enrollee" means a person covered  
17 by a health plan including an enrollee, subscriber, policyholder,  
18 beneficiary of a group plan, or individual covered by any other health  
19 plan.

20 ~~((+9))~~ (10) "Dependent" means, at a minimum, the enrollee's legal  
21 spouse and ~~((unmarried))~~ dependent children who qualify for coverage  
22 under the enrollee's health benefit plan.

23 ~~((+10))~~ (11) "Emergency medical condition" means ~~((the emergent  
24 and acute onset of a symptom or symptoms, including severe pain, that  
25 would lead a prudent layperson acting reasonably to believe that a  
26 health condition exists that requires immediate medical attention, if  
27 failure to provide medical attention would result in serious impairment  
28 to bodily functions or serious dysfunction of a bodily organ or part,  
29 or would place the person's health in serious jeopardy))~~ a medical  
30 condition manifesting itself by acute symptoms of sufficient severity,  
31 including severe pain, such that a prudent layperson, who possesses an  
32 average knowledge of health and medicine, could reasonably expect the  
33 absence of immediate medical attention to result in a condition (a)  
34 placing the health of the individual, or with respect to a pregnant  
35 woman, the health of the woman or her unborn child, in serious  
36 jeopardy, (b) serious impairment to bodily functions, or (c) serious  
37 dysfunction of any bodily organ or part.

1        ~~((+11))~~ (12) "Emergency services" means ~~((otherwise covered health~~  
2 ~~care services medically necessary to evaluate and treat an emergency~~  
3 ~~medical condition, provided in a hospital emergency department))~~ a  
4 medical screening examination, as required under section 1867 of the  
5 social security act (42 U.S.C. 1395dd), that is within the capability  
6 of the emergency department of a hospital, including ancillary services  
7 routinely available to the emergency department to evaluate that  
8 emergency medical condition, and further medical examination and  
9 treatment, to the extent they are within the capabilities of the staff  
10 and facilities available at the hospital, as are required under section  
11 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the  
12 patient. Stabilize, with respect to an emergency medical condition,  
13 has the meaning given in section 1867(e)(3) of the social security act  
14 (42 U.S.C. 1395dd(e)(3)).

15        ~~((+12))~~ (13) "Employee" has the same meaning given to the term, as  
16 of January 1, 2008, under section 3(6) of the federal employee  
17 retirement income security act of 1974.

18        ~~((+13))~~ (14) "Enrollee point-of-service cost-sharing" means  
19 amounts paid to health carriers directly providing services, health  
20 care providers, or health care facilities by enrollees and may include  
21 copayments, coinsurance, or deductibles.

22        ~~((+14))~~ (15) "Final external review decision" means a  
23 determination by an independent review organization at the conclusion  
24 of an external review.

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

31        (17) "Grandfathered health plan" means a group health plan or an  
32 individual health plan that under section 1251 of the patient  
33 protection and affordable care act, P.L. 111-148 (2010) and as amended  
34 by the health care and education reconciliation act, P.L. 111-152  
35 (2010) is not subject to subtitles A or C of the act as amended.

36        (18) "Grievance" means a written complaint submitted by or on  
37 behalf of a covered person regarding: (a) Denial of payment for  
38 medical services or nonprovision of medical services included in the

1 covered person's health benefit plan, or (b) service delivery issues  
2 other than denial of payment for medical services or nonprovision of  
3 medical services, including dissatisfaction with medical care, waiting  
4 time for medical services, provider or staff attitude or demeanor, or  
5 dissatisfaction with service provided by the health carrier.

6 ~~((+15+))~~ (19) "Health care facility" or "facility" means hospices  
7 licensed under chapter 70.127 RCW, hospitals licensed under chapter  
8 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,  
9 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes  
10 licensed under chapter 18.51 RCW, community mental health centers  
11 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment  
12 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,  
13 treatment, or surgical facilities licensed under chapter 70.41 RCW,  
14 drug and alcohol treatment facilities licensed under chapter 70.96A  
15 RCW, and home health agencies licensed under chapter 70.127 RCW, and  
16 includes such facilities if owned and operated by a political  
17 subdivision or instrumentality of the state and such other facilities  
18 as required by federal law and implementing regulations.

19 ~~((+16+))~~ (20) "Health care provider" or "provider" means:

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

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

25 ~~((+17+))~~ (21) "Health care service" means that service offered or  
26 provided by health care facilities and health care providers relating  
27 to the prevention, cure, or treatment of illness, injury, or disease.

28 ~~((+18+))~~ (22) "Health carrier" or "carrier" means a disability  
29 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
30 service contractor as defined in RCW 48.44.010, or a health maintenance  
31 organization as defined in RCW 48.46.020.

32 ~~((+19+))~~ (23) "Health plan" or "health benefit plan" means any  
33 policy, contract, or agreement offered by a health carrier to provide,  
34 arrange, reimburse, or pay for health care services except the  
35 following:

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

- 1 (b) Medicare supplemental health insurance governed by chapter
- 2 48.66 RCW;
- 3 (c) Coverage supplemental to the coverage provided under chapter
- 4 55, Title 10, United States Code;
- 5 (d) Limited health care services offered by limited health care
- 6 service contractors in accordance with RCW 48.44.035;
- 7 (e) Disability income;
- 8 (f) Coverage incidental to a property/casualty liability insurance
- 9 policy such as automobile personal injury protection coverage and
- 10 homeowner guest medical;
- 11 (g) Workers' compensation coverage;
- 12 (h) Accident only coverage;
- 13 (i) Specified disease or illness-triggered fixed payment insurance,
- 14 hospital confinement fixed payment insurance, or other fixed payment
- 15 insurance offered as an independent, noncoordinated benefit;
- 16 (j) Employer-sponsored self-funded health plans;
- 17 (k) Dental only and vision only coverage; and
- 18 (l) Plans deemed by the insurance commissioner to have a short-term
- 19 limited purpose or duration, or to be a student-only plan that is
- 20 guaranteed renewable while the covered person is enrolled as a regular
- 21 full-time undergraduate or graduate student at an accredited higher
- 22 education institution, after a written request for such classification
- 23 by the carrier and subsequent written approval by the insurance
- 24 commissioner.
- 25 ~~((+20))~~ (24) "Material modification" means a change in the
- 26 actuarial value of the health plan as modified of more than five
- 27 percent but less than fifteen percent.
- 28 ~~((+21))~~ (25) "Preexisting condition" means any medical condition,
- 29 illness, or injury that existed any time prior to the effective date of
- 30 coverage.
- 31 ~~((+22))~~ (26) "Premium" means all sums charged, received, or
- 32 deposited by a health carrier as consideration for a health plan or the
- 33 continuance of a health plan. Any assessment or any "membership,"
- 34 "policy," "contract," "service," or similar fee or charge made by a
- 35 health carrier in consideration for a health plan is deemed part of the
- 36 premium. "Premium" shall not include amounts paid as enrollee point-
- 37 of-service cost-sharing.



1        ~~((+23+))~~ (27) "Review organization" means a disability insurer  
2 regulated under chapter 48.20 or 48.21 RCW, health care service  
3 contractor as defined in RCW 48.44.010, or health maintenance  
4 organization as defined in RCW 48.46.020, and entities affiliated with,  
5 under contract with, or acting on behalf of a health carrier to perform  
6 a utilization review.

7        ~~((+24+))~~ (28) "Small employer" or "small group" means any person,  
8 firm, corporation, partnership, association, political subdivision,  
9 sole proprietor, or self-employed individual that is actively engaged  
10 in business that employed an average of at least one but no more than  
11 fifty employees, during the previous calendar year and employed at  
12 least one employee on the first day of the plan year, is not formed  
13 primarily for purposes of buying health insurance, and in which a bona  
14 fide employer-employee relationship exists. In determining the number  
15 of employees, companies that are affiliated companies, or that are  
16 eligible to file a combined tax return for purposes of taxation by this  
17 state, shall be considered an employer. Subsequent to the issuance of  
18 a health plan to a small employer and for the purpose of determining  
19 eligibility, the size of a small employer shall be determined annually.  
20 Except as otherwise specifically provided, a small employer shall  
21 continue to be considered a small employer until the plan anniversary  
22 following the date the small employer no longer meets the requirements  
23 of this definition. A self-employed individual or sole proprietor who  
24 is covered as a group of one must also: (a) Have been employed by the  
25 same small employer or small group for at least twelve months prior to  
26 application for small group coverage, and (b) verify that he or she  
27 derived at least seventy-five percent of his or her income from a trade  
28 or business through which the individual or sole proprietor has  
29 attempted to earn taxable income and for which he or she has filed the  
30 appropriate internal revenue service form 1040, schedule C or F, for  
31 the previous taxable year, except a self-employed individual or sole  
32 proprietor in an agricultural trade or business, must have derived at  
33 least fifty-one percent of his or her income from the trade or business  
34 through which the individual or sole proprietor has attempted to earn  
35 taxable income and for which he or she has filed the appropriate  
36 internal revenue service form 1040, for the previous taxable year.

37        ~~((+25+))~~ (29) "Utilization review" means the prospective,  
38 concurrent, or retrospective assessment of the necessity and

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

4 ((+26+)) (30) "Wellness activity" means an explicit program of an  
5 activity consistent with department of health guidelines, such as,  
6 smoking cessation, injury and accident prevention, reduction of alcohol  
7 misuse, appropriate weight reduction, exercise, automobile and  
8 motorcycle safety, blood cholesterol reduction, and nutrition education  
9 for the purpose of improving enrollee health status and reducing health  
10 service costs.

11 **Sec. 4.** RCW 48.43.530 and 2000 c 5 s 10 are each amended to read  
12 as follows:

13 (1) Each carrier that offers a health plan must have a fully  
14 operational, comprehensive grievance process that complies with the  
15 requirements of this section and any rules adopted by the commissioner  
16 to implement this section. For the purposes of this section, the  
17 commissioner shall consider grievance process standards adopted by  
18 national managed care accreditation organizations and state agencies  
19 that purchase managed health care services, and for health plans that  
20 are not grandfathered health plans as approved by the United States  
21 department of health and human services or the United States department  
22 of labor.

23 (2) Each carrier must process as a complaint an enrollee's  
24 expression of dissatisfaction about customer service or the quality or  
25 availability of a health service. Each carrier must implement  
26 procedures for registering and responding to oral and written  
27 complaints in a timely and thorough manner.

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

33 (4) Each carrier must process as an appeal an enrollee's written or  
34 oral request that the carrier reconsider: (a) Its resolution of a  
35 complaint made by an enrollee; or (b) its decision to deny, modify,  
36 reduce, or terminate payment, coverage, authorization, or provision of  
37 health care services or benefits, including the admission to, or

1 continued stay in, a health care facility. A carrier must not require  
2 that an enrollee file a complaint prior to seeking appeal of a decision  
3 under (b) of this subsection.

4 (5) To process an appeal, each carrier must:

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

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

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

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

17 (e) Consider information submitted by the enrollee;

18 (f) Investigate and resolve the appeal; and

19 (g) Provide written notice of its resolution of the appeal to the  
20 enrollee and, with the permission of the enrollee, to the enrollee's  
21 providers. The written notice must explain the carrier's decision and  
22 the supporting coverage or clinical reasons and the enrollee's right to  
23 request independent review of the carrier's decision under RCW  
24 48.43.535.

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

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

29 (b) The carrier's appeal process, including information, as  
30 appropriate, about how to exercise the enrollee's rights to obtain a  
31 second opinion, and how to continue receiving services as provided in  
32 this section.

33 (7) When an enrollee requests that the carrier reconsider its  
34 decision to modify, reduce, or terminate an otherwise covered health  
35 service that an enrollee is receiving through the health plan and the  
36 carrier's decision is based upon a finding that the health service, or  
37 level of health service, is no longer medically necessary or  
38 appropriate, the carrier must continue to provide that health service

1 until the appeal is resolved. If the resolution of the appeal or any  
2 review sought by the enrollee under RCW 48.43.535 affirms the carrier's  
3 decision, the enrollee may be responsible for the cost of this  
4 continued health service.

5 (8) Each carrier must provide a clear explanation of the grievance  
6 process upon request, upon enrollment to new enrollees, and annually to  
7 enrollees and subcontractors.

8 (9) Each carrier must ensure that the grievance process is  
9 accessible to enrollees who are limited English speakers, who have  
10 literacy problems, or who have physical or mental disabilities that  
11 impede their ability to file a grievance.

12 (10) Each carrier must: Track each appeal until final resolution;  
13 maintain, and make accessible to the commissioner for a period of three  
14 years, a log of all appeals; and identify and evaluate trends in  
15 appeals.

16 **Sec. 5.** RCW 48.43.535 and 2000 c 5 s 11 are each amended to read  
17 as follows:

18 (1) There is a need for a process for the fair consideration of  
19 disputes relating to decisions by carriers that offer a health plan to  
20 deny, modify, reduce, or terminate coverage of or payment for health  
21 care services for an enrollee.

22 (2) An enrollee may seek review by a certified independent review  
23 organization of a carrier's decision to deny, modify, reduce, or  
24 terminate coverage of or payment for a health care service, after  
25 exhausting the carrier's grievance process and receiving a decision  
26 that is unfavorable to the enrollee, or after the carrier has exceeded  
27 the timelines for grievances provided in RCW 48.43.530, without good  
28 cause and without reaching a decision.

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

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

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

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

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

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

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

23 (6) The medical reviewers from a certified independent review  
24 organization will make determinations regarding the medical necessity  
25 or appropriateness of, and the application of health plan coverage  
26 provisions to, health care services for an enrollee. The medical  
27 reviewers' determinations must be based upon their expert medical  
28 judgment, after consideration of relevant medical, scientific, and  
29 cost-effectiveness evidence, and medical standards of practice in the  
30 state of Washington. Except as provided in this subsection, the  
31 certified independent review organization must ensure that  
32 determinations are consistent with the scope of covered benefits as  
33 outlined in the medical coverage agreement. Medical reviewers may  
34 override the health plan's medical necessity or appropriateness  
35 standards if the standards are determined upon review to be  
36 unreasonable or inconsistent with sound, evidence-based medical  
37 practice.

1        ~~((+6))~~ (7) Once a request for an independent review determination  
2 has been made, the independent review organization must proceed to a  
3 final determination, unless requested otherwise by both the carrier and  
4 the enrollee or the enrollee's representative.

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

22        (b) For claims involving experimental or investigational  
23 treatments, the internal review organization must ensure that adequate  
24 clinical and scientific experience and protocols are taken into account  
25 as part of the external review process.

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

29        ~~((+8))~~ (9) When an enrollee requests independent review of a  
30 dispute under this section, and the dispute involves a carrier's  
31 decision to modify, reduce, or terminate an otherwise covered health  
32 service that an enrollee is receiving at the time the request for  
33 review is submitted and the carrier's decision is based upon a finding  
34 that the health service, or level of health service, is no longer  
35 medically necessary or appropriate, the carrier must continue to  
36 provide the health service if requested by the enrollee until a  
37 determination is made under this section. If the determination affirms

1 the carrier's decision, the enrollee may be responsible for the cost of  
2 the continued health service.

3 ~~((+9))~~ (10) Each certified independent review organization must  
4 maintain written records and make them available upon request to the  
5 commissioner.

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

10 ~~((+10))~~ (12)(a) The commissioner shall adopt rules to implement  
11 this section after considering relevant standards adopted by national  
12 managed care accreditation organizations and the national association  
13 of insurance commissioners.

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

17 **Sec. 6.** RCW 48.44.215 and 2007 c 259 s 21 are each amended to read  
18 as follows:

19 (1) Any individual health care service plan contract that provides  
20 coverage for a subscriber's dependent must offer the option of covering  
21 any ~~((unmarried))~~ dependent under the age of ~~((twenty-five))~~ twenty-  
22 six.

23 (2) Any group health care service plan contract that provides  
24 coverage for a participating member's dependent must offer each  
25 participating member the option of covering any ~~((unmarried))~~ dependent  
26 under the age of ~~((twenty-five))~~ twenty-six.

27 **Sec. 7.** RCW 48.44.380 and 1984 c 190 s 7 are each amended to read  
28 as follows:

29 (1) A health care service contractor shall not require proof of  
30 insurability as a condition for issuance of the conversion contract.

31 (2) A conversion contract may not contain an exclusion for  
32 preexisting conditions ~~((except))~~ for any applicant who is under age  
33 nineteen. For policies issued to those age nineteen and older, an  
34 exclusion for a preexisting condition is permitted only to the extent  
35 that a waiting period for a preexisting condition has not been  
36 satisfied under the group contract.

1 (3) A health care service contractor must offer at least three  
2 contract benefit plans that comply with the following:

3 (a) A major medical plan with a five thousand dollar deductible  
4 (~~((and a lifetime benefit maximum of two hundred fifty thousand~~  
5 ~~dollars))~~) per person;

6 (b) A comprehensive medical plan with a five hundred dollar  
7 deductible (~~((and a lifetime benefit maximum of five hundred thousand~~  
8 ~~dollars))~~) per person; and

9 (c) A basic medical plan with a one thousand dollar deductible  
10 (~~((and a lifetime maximum of seventy five thousand dollars))~~) per person.

11 (4) The insurance commissioner may revise the (~~(deductibles and~~  
12 ~~lifetime benefit)) deductible amounts in subsection (3) of this section  
13 from time to time to reflect changing health care costs.~~

14 (5) The insurance commissioner shall adopt rules to establish  
15 minimum benefit standards for conversion contracts.

16 (6) The commissioner shall adopt rules to establish specific  
17 standards for conversion contract provisions. These rules may include  
18 but are not limited to:

19 (a) Terms of renewability;

20 (b) Nonduplication of coverage;

21 (c) Benefit limitations, exceptions, and reductions; and

22 (d) Definitions of terms.

23 **Sec. 8.** RCW 48.46.325 and 2007 c 259 s 22 are each amended to read  
24 as follows:

25 (1) Any individual health maintenance agreement that provides  
26 coverage for a subscriber's dependent must offer the option of covering  
27 any (~~(unmarried))~~ dependent under the age of (~~(twenty-five))~~ twenty-  
28 six.

29 (2) Any group health maintenance agreement that provides coverage  
30 for a participating member's dependent must offer each participating  
31 member the option of covering any (~~(unmarried))~~ dependent under the age  
32 of (~~(twenty-five))~~ twenty-six.

33 **Sec. 9.** RCW 48.46.460 and 1984 c 190 s 10 are each amended to read  
34 as follows:

35 (1) A health maintenance organization must offer a conversion



1 agreement for comprehensive health care services and shall not require  
2 proof of insurability as a condition for issuance of the conversion  
3 agreement.

4 (2) A conversion agreement may not contain an exclusion for  
5 preexisting conditions (~~except~~) for an applicant who is under age  
6 nineteen. For policies issued to those age nineteen and older, an  
7 exclusion for a preexisting condition is permitted only to the extent  
8 that a waiting period for a preexisting condition has not been  
9 satisfied under the group agreement.

10 (3) A conversion agreement need not provide benefits identical to  
11 those provided under the group agreement. The conversion agreement may  
12 contain provisions requiring the person covered by the conversion  
13 agreement to pay reasonable deductibles and copayments, except for  
14 preventive service benefits as defined in 45 C.F.R. 147.130 (2010),  
15 implementing sections 2701 through 2763, 2791, and 2792 of the public  
16 health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and  
17 300gg-92), as amended.

18 (4) The insurance commissioner shall adopt rules to establish  
19 minimum benefit standards for conversion agreements.

20 (5) The commissioner shall adopt rules to establish specific  
21 standards for conversion agreement provisions. These rules may include  
22 but are not limited to:

- 23 (a) Terms of renewability;
- 24 (b) Nonduplication of coverage;
- 25 (c) Benefit limitations, exceptions, and reductions; and
- 26 (d) Definitions of terms.

27 **Sec. 10.** RCW 48.20.025 and 2008 c 303 s 4 are each amended to read  
28 as follows:

29 (1) The definitions in this subsection apply throughout this  
30 section unless the context clearly requires otherwise.

31 (a) "Claims" means the cost to the insurer of health care services,  
32 as defined in RCW 48.43.005, provided to a policyholder or paid to or  
33 on behalf of the policyholder in accordance with the terms of a health  
34 benefit plan, as defined in RCW 48.43.005. This includes capitation  
35 payments or other similar payments made to providers for the purpose of  
36 paying for health care services for a policyholder.

1 (b) "Claims reserves" means: (i) The liability for claims which  
2 have been reported but not paid; (ii) the liability for claims which  
3 have not been reported but which may reasonably be expected; (iii)  
4 active life reserves; and (iv) additional claims reserves whether for  
5 a specific liability purpose or not.

6 (c) "Declination rate" for an insurer means the percentage of the  
7 total number of applicants for individual health benefit plans received  
8 by that insurer in the aggregate in the applicable year which are not  
9 accepted for enrollment by that insurer based on the results of the  
10 standard health questionnaire administered pursuant to RCW  
11 48.43.018(2)(a).

12 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
13 plus any rate credits or recoupments less any refunds, for the  
14 applicable period, whether received before, during, or after the  
15 applicable period.

16 (e) "Incurred claims expense" means claims paid during the  
17 applicable period plus any increase, or less any decrease, in the  
18 claims reserves.

19 (f) "Loss ratio" means incurred claims expense as a percentage of  
20 earned premiums.

21 (g) "Reserves" means: (i) Active life reserves; and (ii)  
22 additional reserves whether for a specific liability purpose or not.

23 (2) An insurer must file supporting documentation of its method of  
24 determining the rates charged for its individual health benefit plans.  
25 At a minimum, the insurer must provide the following supporting  
26 documentation:

27 (a) A description of the insurer's rate-making methodology;

28 (b) An actuarially determined estimate of incurred claims which  
29 includes the experience data, assumptions, and justifications of the  
30 insurer's projection;

31 (c) The percentage of premium attributable in aggregate for  
32 nonclaims expenses used to determine the adjusted community rates  
33 charged; and

34 (d) A certification by a member of the American academy of  
35 actuaries, or other person approved by the commissioner, that the  
36 adjusted community rate charged can be reasonably expected to result in  
37 a loss ratio that meets or exceeds the loss ratio standard of

1 seventy-four percent, minus the premium tax rate applicable to the  
2 insurer's individual health benefit plans under RCW 48.14.020.

3 ~~((3) By the last day of May each year any insurer issuing or  
4 renewing individual health benefit plans in this state during the  
5 preceding calendar year shall file for review by the commissioner  
6 supporting documentation of its actual loss ratio and its actual  
7 declination rate for its individual health benefit plans offered or  
8 renewed in the state in aggregate for the preceding calendar year. The  
9 filing shall include aggregate earned premiums, aggregate incurred  
10 claims, and a certification by a member of the American academy of  
11 actuaries, or other person approved by the commissioner, that the  
12 actual loss ratio has been calculated in accordance with accepted  
13 actuarial principles.~~

14 ~~(a) At the expiration of a thirty-day period beginning with the  
15 date the filing is received by the commissioner, the filing shall be  
16 deemed approved unless prior thereto the commissioner contests the  
17 calculation of the actual loss ratio.~~

18 ~~(b) If the commissioner contests the calculation of the actual loss  
19 ratio, the commissioner shall state in writing the grounds for  
20 contesting the calculation to the insurer.~~

21 ~~(c) Any dispute regarding the calculation of the actual loss ratio  
22 shall, upon written demand of either the commissioner or the insurer,  
23 be submitted to hearing under chapters 48.04 and 34.05 RCW.~~

24 ~~(4) If the actual loss ratio for the preceding calendar year is  
25 less than the loss ratio established in subsection (5) of this section,  
26 a remittance is due and the following shall apply:~~

27 ~~(a) The insurer shall calculate a percentage of premium to be  
28 remitted to the Washington state health insurance pool by subtracting  
29 the actual loss ratio for the preceding year from the loss ratio  
30 established in subsection (5) of this section.~~

31 ~~(b) The remittance to the Washington state health insurance pool is  
32 the percentage calculated in (a) of this subsection, multiplied by the  
33 premium earned from each enrollee in the previous calendar year.  
34 Interest shall be added to the remittance due at a five percent annual  
35 rate calculated from the end of the calendar year for which the  
36 remittance is due to the date the remittance is made.~~

37 ~~(c) All remittances shall be aggregated and such amounts shall be~~

1 ~~remitted to the Washington state high risk pool to be used as directed~~  
2 ~~by the pool board of directors.~~

3 ~~(d) Any remittance required to be issued under this section shall~~  
4 ~~be issued within thirty days after the actual loss ratio is deemed~~  
5 ~~approved under subsection (3)(a) of this section or the determination~~  
6 ~~by an administrative law judge under subsection (3)(c) of this section.~~

7 ~~(5) The loss ratio applicable to this section shall be the~~  
8 ~~percentage set forth in the following schedule that correlates to the~~  
9 ~~insurer's actual declination rate in the preceding year, minus the~~  
10 ~~premium tax rate applicable to the insurer's individual health benefit~~  
11 ~~plans under RCW 48.14.020.~~

12	Actual Declination Rate	Loss Ratio
13	Under Six Percent (6%)	Seventy-Four Percent (74%)
14	Six Percent (6%) or more (but less than Seven Percent)	Seventy-Five Percent (75%)
15	Seven Percent (7%) or more (but less than Eight Percent)	Seventy-Six Percent (76%)
16	Eight Percent (8%) or more	Seventy-Seven Percent (77%))

17 **Sec. 11.** RCW 48.44.017 and 2008 c 303 s 5 are each amended to read  
18 as follows:

19 (1) The definitions in this subsection apply throughout this  
20 section unless the context clearly requires otherwise.

21 (a) "Claims" means the cost to the health care service contractor  
22 of health care services, as defined in RCW 48.43.005, provided to a  
23 contract holder or paid to or on behalf of a contract holder in  
24 accordance with the terms of a health benefit plan, as defined in RCW  
25 48.43.005. This includes capitation payments or other similar payments  
26 made to providers for the purpose of paying for health care services  
27 for an enrollee.

28 (b) "Claims reserves" means: (i) The liability for claims which  
29 have been reported but not paid; (ii) the liability for claims which  
30 have not been reported but which may reasonably be expected; (iii)  
31 active life reserves; and (iv) additional claims reserves whether for  
32 a specific liability purpose or not.

33 (c) "Declination rate" for a health care service contractor means  
34 the percentage of the total number of applicants for individual health  
35 benefit plans received by that health care service contractor in the  
36 aggregate in the applicable year which are not accepted for enrollment

1 by that health care service contractor based on the results of the  
2 standard health questionnaire administered pursuant to RCW  
3 48.43.018(2)(a).

4 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
5 plus any rate credits or recoupments less any refunds, for the  
6 applicable period, whether received before, during, or after the  
7 applicable period.

8 (e) "Incurred claims expense" means claims paid during the  
9 applicable period plus any increase, or less any decrease, in the  
10 claims reserves.

11 (f) "Loss ratio" means incurred claims expense as a percentage of  
12 earned premiums.

13 (g) "Reserves" means: (i) Active life reserves; and (ii)  
14 additional reserves whether for a specific liability purpose or not.

15 (2) A health care service contractor must file supporting  
16 documentation of its method of determining the rates charged for its  
17 individual contracts. At a minimum, the health care service contractor  
18 must provide the following supporting documentation:

19 (a) A description of the health care service contractor's rate-  
20 making methodology;

21 (b) An actuarially determined estimate of incurred claims which  
22 includes the experience data, assumptions, and justifications of the  
23 health care service contractor's projection;

24 (c) The percentage of premium attributable in aggregate for  
25 nonclaims expenses used to determine the adjusted community rates  
26 charged; and

27 (d) A certification by a member of the American academy of  
28 actuaries, or other person approved by the commissioner, that the  
29 adjusted community rate charged can be reasonably expected to result in  
30 a loss ratio that meets or exceeds the loss ratio standard of  
31 seventy-four percent, minus the premium tax rate applicable to the  
32 carrier's individual health benefit plans under RCW 48.14.0201.

33 ~~((3) By the last day of May each year any health care service~~  
34 ~~contractor issuing or renewing individual health benefit plans in this~~  
35 ~~state during the preceding calendar year shall file for review by the~~  
36 ~~commissioner supporting documentation of its actual loss ratio and its~~  
37 ~~actual declination rate for its individual health benefit plans offered~~  
38 ~~or renewed in this state in aggregate for the preceding calendar year.~~

1 The filing shall include aggregate earned premiums, aggregate incurred  
2 claims, and a certification by a member of the American academy of  
3 actuaries, or other person approved by the commissioner, that the  
4 actual loss ratio has been calculated in accordance with accepted  
5 actuarial principles.

6 (a) At the expiration of a thirty-day period beginning with the  
7 date the filing is received by the commissioner, the filing shall be  
8 deemed approved unless prior thereto the commissioner contests the  
9 calculation of the actual loss ratio.

10 (b) If the commissioner contests the calculation of the actual loss  
11 ratio, the commissioner shall state in writing the grounds for  
12 contesting the calculation to the health care service contractor.

13 (c) Any dispute regarding the calculation of the actual loss ratio  
14 shall upon written demand of either the commissioner or the health care  
15 service contractor be submitted to hearing under chapters 48.04 and  
16 34.05 RCW.

17 (4) If the actual loss ratio for the preceding calendar year is  
18 less than the loss ratio standard established in subsection (5) of this  
19 section, a remittance is due and the following shall apply:

20 (a) The health care service contractor shall calculate a percentage  
21 of premium to be remitted to the Washington state health insurance pool  
22 by subtracting the actual loss ratio for the preceding year from the  
23 loss ratio established in subsection (5) of this section.

24 (b) The remittance to the Washington state health insurance pool is  
25 the percentage calculated in (a) of this subsection, multiplied by the  
26 premium earned from each enrollee in the previous calendar year.  
27 Interest shall be added to the remittance due at a five percent annual  
28 rate calculated from the end of the calendar year for which the  
29 remittance is due to the date the remittance is made.

30 (c) All remittances shall be aggregated and such amounts shall be  
31 remitted to the Washington state high risk pool to be used as directed  
32 by the pool board of directors.

33 (d) Any remittance required to be issued under this section shall  
34 be issued within thirty days after the actual loss ratio is deemed  
35 approved under subsection (3)(a) of this section or the determination  
36 by an administrative law judge under subsection (3)(c) of this section.

37 (5) The loss ratio applicable to this section shall be the  
38 percentage set forth in the following schedule that correlates to the

1 ~~health care service contractor's actual declination rate in the~~  
2 ~~preceding year, minus the premium tax rate applicable to the health~~  
3 ~~care service contractor's individual health benefit plans under RCW~~  
4 ~~48.14.0201.~~

5	Actual Declination Rate	Loss Ratio
6	Under Six Percent (6%)	Seventy-Four Percent (74%)
7	Six Percent (6%) or more (but less than Seven Percent)	Seventy-Five Percent (75%)
8	Seven Percent (7%) or more (but less than Eight Percent)	Seventy-Six Percent (76%)
9	Eight Percent (8%) or more	Seventy-Seven Percent (77%))

10 **Sec. 12.** RCW 48.46.062 and 2008 c 303 s 6 are each amended to read  
11 as follows:

12 (1) The definitions in this subsection apply throughout this  
13 section unless the context clearly requires otherwise.

14 (a) "Claims" means the cost to the health maintenance organization  
15 of health care services, as defined in RCW 48.43.005, provided to an  
16 enrollee or paid to or on behalf of the enrollee in accordance with the  
17 terms of a health benefit plan, as defined in RCW 48.43.005. This  
18 includes capitation payments or other similar payments made to  
19 providers for the purpose of paying for health care services for an  
20 enrollee.

21 (b) "Claims reserves" means: (i) The liability for claims which  
22 have been reported but not paid; (ii) the liability for claims which  
23 have not been reported but which may reasonably be expected; (iii)  
24 active life reserves; and (iv) additional claims reserves whether for  
25 a specific liability purpose or not.

26 (c) "Declination rate" for a health maintenance organization means  
27 the percentage of the total number of applicants for individual health  
28 benefit plans received by that health maintenance organization in the  
29 aggregate in the applicable year which are not accepted for enrollment  
30 by that health maintenance organization based on the results of the  
31 standard health questionnaire administered pursuant to RCW  
32 48.43.018(2)(a).

33 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
34 plus any rate credits or recoupments less any refunds, for the  
35 applicable period, whether received before, during, or after the  
36 applicable period.

1 (e) "Incurred claims expense" means claims paid during the  
2 applicable period plus any increase, or less any decrease, in the  
3 claims reserves.

4 (f) "Loss ratio" means incurred claims expense as a percentage of  
5 earned premiums.

6 (g) "Reserves" means: (i) Active life reserves; and (ii)  
7 additional reserves whether for a specific liability purpose or not.

8 (2) A health maintenance organization must file supporting  
9 documentation of its method of determining the rates charged for its  
10 individual agreements. At a minimum, the health maintenance  
11 organization must provide the following supporting documentation:

12 (a) A description of the health maintenance organization's rate-  
13 making methodology;

14 (b) An actuarially determined estimate of incurred claims which  
15 includes the experience data, assumptions, and justifications of the  
16 health maintenance organization's projection;

17 (c) The percentage of premium attributable in aggregate for  
18 nonclaims expenses used to determine the adjusted community rates  
19 charged; and

20 (d) A certification by a member of the American academy of  
21 actuaries, or other person approved by the commissioner, that the  
22 adjusted community rate charged can be reasonably expected to result in  
23 a loss ratio that meets or exceeds the loss ratio standard of  
24 seventy-four percent, minus the premium tax rate applicable to the  
25 carrier's individual health benefit plans under RCW 48.14.0201.

26 ~~((3) By the last day of May each year any health maintenance~~  
27 ~~organization issuing or renewing individual health benefit plans in~~  
28 ~~this state during the preceding calendar year shall file for review by~~  
29 ~~the commissioner supporting documentation of its actual loss ratio and~~  
30 ~~its actual declination rate for its individual health benefit plans~~  
31 ~~offered or renewed in the state in aggregate for the preceding calendar~~  
32 ~~year. The filing shall include aggregate earned premiums, aggregate~~  
33 ~~incurred claims, and a certification by a member of the American~~  
34 ~~academy of actuaries, or other person approved by the commissioner,~~  
35 ~~that the actual loss ratio has been calculated in accordance with~~  
36 ~~accepted actuarial principles.~~

37 ~~(a) At the expiration of a thirty day period beginning with the~~



1 ~~date the filing is received by the commissioner, the filing shall be~~  
2 ~~deemed approved unless prior thereto the commissioner contests the~~  
3 ~~calculation of the actual loss ratio.~~

4 ~~(b) If the commissioner contests the calculation of the actual loss~~  
5 ~~ratio, the commissioner shall state in writing the grounds for~~  
6 ~~contesting the calculation to the health maintenance organization.~~

7 ~~(c) Any dispute regarding the calculation of the actual loss ratio~~  
8 ~~shall, upon written demand of either the commissioner or the health~~  
9 ~~maintenance organization, be submitted to hearing under chapters 48.04~~  
10 ~~and 34.05 RCW.~~

11 ~~(4) If the actual loss ratio for the preceding calendar year is~~  
12 ~~less than the loss ratio standard established in subsection (5) of this~~  
13 ~~section, a remittance is due and the following shall apply:~~

14 ~~(a) The health maintenance organization shall calculate a~~  
15 ~~percentage of premium to be remitted to the Washington state health~~  
16 ~~insurance pool by subtracting the actual loss ratio for the preceding~~  
17 ~~year from the loss ratio established in subsection (5) of this section.~~

18 ~~(b) The remittance to the Washington state health insurance pool is~~  
19 ~~the percentage calculated in (a) of this subsection, multiplied by the~~  
20 ~~premium earned from each enrollee in the previous calendar year.~~  
21 ~~Interest shall be added to the remittance due at a five percent annual~~  
22 ~~rate calculated from the end of the calendar year for which the~~  
23 ~~remittance is due to the date the remittance is made.~~

24 ~~(c) All remittances shall be aggregated and such amounts shall be~~  
25 ~~remitted to the Washington state high risk pool to be used as directed~~  
26 ~~by the pool board of directors.~~

27 ~~(d) Any remittance required to be issued under this section shall~~  
28 ~~be issued within thirty days after the actual loss ratio is deemed~~  
29 ~~approved under subsection (3)(a) of this section or the determination~~  
30 ~~by an administrative law judge under subsection (3)(c) of this section.~~

31 ~~(5) The loss ratio applicable to this section shall be the~~  
32 ~~percentage set forth in the following schedule that correlates to the~~  
33 ~~health maintenance organization's actual declination rate in the~~  
34 ~~preceding year, minus the premium tax rate applicable to the health~~  
35 ~~maintenance organization's individual health benefit plans under RCW~~  
36 ~~48.14.0201.~~

1	Actual Declination Rate	Loss Ratio
2	Under Six Percent (6%)	Seventy-Four Percent (74%)
3	Six Percent (6%) or more (but less than Seven Percent)	Seventy-Five Percent (75%)
4	Seven Percent (7%) or more (but less than Eight Percent)	Seventy-Six Percent (76%)
5	Eight Percent (8%) or more	Seventy-Seven Percent (77%))

6       **Sec. 13.** RCW 48.41.060 and 2009 c 555 s 2 are each amended to read  
7 as follows:

8       (1) The board shall have the general powers and authority granted  
9 under the laws of this state to insurance companies, health care  
10 service contractors, and health maintenance organizations, licensed or  
11 registered to offer or provide the kinds of health coverage defined  
12 under this title. In addition thereto, the board shall:

13       (a) Designate or establish the standard health questionnaire to be  
14 used under RCW 48.41.100 and 48.43.018, including the form and content  
15 of the standard health questionnaire and the method of its application.  
16 The questionnaire must provide for an objective evaluation of an  
17 individual's health status by assigning a discreet measure, such as a  
18 system of point scoring to each individual. The questionnaire must not  
19 contain any questions related to pregnancy, and pregnancy shall not be  
20 a basis for coverage by the pool. The questionnaire shall be designed  
21 such that it is reasonably expected to identify the eight percent of  
22 persons who are the most costly to treat who are under individual  
23 coverage in health benefit plans, as defined in RCW 48.43.005, in  
24 Washington state or are covered by the pool, if applied to all such  
25 persons;

26       (b) Obtain from a member of the American academy of actuaries, who  
27 is independent of the board, a certification that the standard health  
28 questionnaire meets the requirements of (a) of this subsection;

29       (c) Approve the standard health questionnaire and any modifications  
30 needed to comply with this chapter. The standard health questionnaire  
31 shall be submitted to an actuary for certification, modified as  
32 necessary, and approved at least every thirty-six months unless at the  
33 time when certification is required the pool will be discontinued  
34 before the end of the succeeding thirty-six month period. The  
35 designation and approval of the standard health questionnaire by the  
36 board shall not be subject to review and approval by the commissioner.

1 The standard health questionnaire or any modification thereto shall not  
2 be used until ninety days after public notice of the approval of the  
3 questionnaire or any modification thereto, except that the initial  
4 standard health questionnaire approved for use by the board after March  
5 23, 2000, may be used immediately following public notice of such  
6 approval;

7 (d) Establish appropriate rates, rate schedules, rate adjustments,  
8 expense allowances, claim reserve formulas and any other actuarial  
9 functions appropriate to the operation of the pool. Rates shall not be  
10 unreasonable in relation to the coverage provided, the risk experience,  
11 and expenses of providing the coverage. Rates and rate schedules may  
12 be adjusted for appropriate risk factors such as age and area variation  
13 in claim costs and shall take into consideration appropriate risk  
14 factors in accordance with established actuarial underwriting practices  
15 consistent with Washington state individual plan rating requirements  
16 under RCW 48.44.022 and 48.46.064;

17 (e)(i) Assess members of the pool in accordance with the provisions  
18 of this chapter, and make advance interim assessments as may be  
19 reasonable and necessary for the organizational or interim operating  
20 expenses. Any interim assessments will be credited as offsets against  
21 any regular assessments due following the close of the year.

22 (ii) Self-funded multiple employer welfare arrangements are subject  
23 to assessment under this subsection only in the event that assessments  
24 are not preempted by the employee retirement income security act of  
25 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the  
26 commissioner shall initially request an advisory opinion from the  
27 United States department of labor or obtain a declaratory ruling from  
28 a federal court on the legality of imposing assessments on these  
29 arrangements before imposing the assessment. Once the legality of the  
30 assessments has been determined, the multiple employer welfare  
31 arrangement certified by the insurance commissioner must begin payment  
32 of these assessments.

33 (iii) If there has not been a final determination of the legality  
34 of these assessments, then beginning on the earlier of (A) the date the  
35 fourth multiple employer welfare arrangement has been certified by the  
36 insurance commissioner, or (B) April 1, 2006, the arrangement shall  
37 deposit the assessments imposed by this subsection into an interest  
38 bearing escrow account maintained by the arrangement. Upon a final

1 determination that the assessments are not preempted by the employee  
2 retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001  
3 et seq., all funds in the interest bearing escrow account shall be  
4 transferred to the board;

5 (f) Issue policies of health coverage in accordance with the  
6 requirements of this chapter;

7 (g) Establish procedures for the administration of the premium  
8 discount provided under RCW 48.41.200(3)(a)(iii);

9 (h) Contract with the Washington state health care authority for  
10 the administration of the premium discounts provided under RCW  
11 48.41.200(3)(a) (i) and (ii);

12 (i) Set a reasonable fee to be paid to an insurance producer  
13 licensed in Washington state for submitting an acceptable application  
14 for enrollment in the pool; and

15 (j) Provide certification to the commissioner when assessments will  
16 exceed the threshold level established in RCW 48.41.037.

17 (2) In addition thereto, the board may:

18 (a) Enter into contracts as are necessary or proper to carry out  
19 the provisions and purposes of this chapter including the authority,  
20 with the approval of the commissioner, to enter into contracts with  
21 similar pools of other states for the joint performance of common  
22 administrative functions, or with persons or other organizations for  
23 the performance of administrative functions;

24 (b) Sue or be sued, including taking any legal action as necessary  
25 to avoid the payment of improper claims against the pool or the  
26 coverage provided by or through the pool;

27 (c) Appoint appropriate legal, actuarial, and other committees as  
28 necessary to provide technical assistance in the operation of the pool,  
29 policy, and other contract design, and any other function within the  
30 authority of the pool; and

31 (d) Conduct periodic audits to assure the general accuracy of the  
32 financial data submitted to the pool, and the board shall cause the  
33 pool to have an annual audit of its operations by an independent  
34 certified public accountant.

35 (3) Nothing in this section shall be construed to require or  
36 authorize the adoption of rules under chapter 34.05 RCW.

1       **Sec. 14.** RCW 48.41.080 and 2000 c 79 s 10 are each amended to read  
2 as follows:

3       The board shall select an administrator through a competitive  
4 bidding process to administer the pool.

5       (1) The board shall evaluate bids based upon criteria established  
6 by the board, which shall include:

7       (a) The administrator's proven ability to handle health coverage;

8       (b) The efficiency of the administrator's claim-paying procedures;

9       (c) An estimate of the total charges for administering the plan;

10 and

11       (d) The administrator's ability to administer the pool in a cost-  
12 effective manner.

13       (2) The administrator shall serve for a period of three years  
14 subject to removal for cause. At least six months prior to the  
15 expiration of each three-year period of service by the administrator,  
16 the board shall invite all interested parties, including the current  
17 administrator, to submit bids to serve as the administrator for the  
18 succeeding three-year period. Selection of the administrator for this  
19 succeeding period shall be made at least three months prior to the end  
20 of the current three-year period, unless at the time required for  
21 submission of bids pursuant to this subsection to the pool will be  
22 discontinued before the end of the succeeding thirty-six month period.

23       (3) The administrator shall perform such duties as may be assigned  
24 by the board including:

25       (a) Administering eligibility and administrative claim payment  
26 functions relating to the pool;

27       (b) Establishing a premium billing procedure for collection of  
28 premiums from covered persons. Billings shall be made on a periodic  
29 basis as determined by the board, which shall not be more frequent than  
30 a monthly billing;

31       (c) Performing all necessary functions to assure timely payment of  
32 benefits to covered persons under the pool including:

33       (i) Making available information relating to the proper manner of  
34 submitting a claim for benefits to the pool, and distributing forms  
35 upon which submission shall be made;

36       (ii) Taking steps necessary to offer and administer managed care  
37 benefit plans; and

1 (iii) Evaluating the eligibility of each claim for payment by the  
2 pool;

3 (d) Submission of regular reports to the board regarding the  
4 operation of the pool. The frequency, content, and form of the report  
5 shall be as determined by the board;

6 (e) Following the close of each accounting year, determination of  
7 net paid and earned premiums, the expense of administration, and the  
8 paid and incurred losses for the year and reporting this information to  
9 the board and the commissioner on a form as prescribed by the  
10 commissioner.

11 (4) The administrator shall be paid as provided in the contract  
12 between the board and the administrator for its expenses incurred in  
13 the performance of its services.

14 **Sec. 15.** RCW 48.41.100 and 2009 c 555 s 3 are each amended to read  
15 as follows:

16 (1)(a) The following persons who are residents of this state are  
17 eligible for pool coverage:

18 (i) Any person who provides evidence of a carrier's decision not to  
19 accept him or her for enrollment in an individual health benefit plan  
20 as defined in RCW 48.43.005 based upon, and within ninety days of the  
21 receipt of, the results of the standard health questionnaire designated  
22 by the board and administered by health carriers under RCW 48.43.018;

23 (ii) Any person who continues to be eligible for pool coverage  
24 based upon the results of the standard health questionnaire designated  
25 by the board and administered by the pool administrator pursuant to  
26 subsection (3) of this section;

27 (iii) Any person who resides in a county of the state where no  
28 carrier or insurer eligible under chapter 48.15 RCW offers to the  
29 public an individual health benefit plan other than a catastrophic  
30 health plan as defined in RCW 48.43.005 at the time of application to  
31 the pool, and who makes direct application to the pool;

32 (iv) Any person becoming eligible for medicare before August 1,  
33 2009, who provides evidence of (A) a rejection for medical reasons, (B)  
34 a requirement of restrictive riders, (C) an up-rated premium, (D) a  
35 preexisting conditions limitation, or (E) lack of access to or for a  
36 comprehensive medicare supplemental insurance policy under chapter

1 48.66 RCW, the effect of any of which is to substantially reduce  
2 coverage from that received by a person considered a standard risk by  
3 at least one member within six months of the date of application; and

4 (v) Any person becoming eligible for medicare on or after August 1,  
5 2009, who does not have access to a reasonable choice of comprehensive  
6 medicare part C plans, as defined in (b) of this subsection, and who  
7 provides evidence of (A) a rejection for medical reasons, (B) a  
8 requirement of restrictive riders, (C) an up-rated premium, (D) a  
9 preexisting conditions limitation, or (E) lack of access to or for a  
10 comprehensive medicare supplemental insurance policy under chapter  
11 48.66 RCW, the effect of any of which is to substantially reduce  
12 coverage from that received by a person considered a standard risk by  
13 at least one member within six months of the date of application.

14 (b) For purposes of (a)(v) of this subsection (1), a person does  
15 not have access to a reasonable choice of plans unless the person has  
16 a choice of health maintenance organization or preferred provider  
17 organization medicare part C plans offered by at least three different  
18 carriers that have had provider networks in the person's county of  
19 residence for at least five years. The plan options must include  
20 coverage at least as comprehensive as a plan F medicare supplement plan  
21 combined with medicare parts A and B. The plan options must also  
22 provide access to adequate and stable provider networks that make up-  
23 to-date provider directories easily accessible on the carrier web site,  
24 and will provide them in hard copy, if requested. In addition, if no  
25 health maintenance organization or preferred provider organization plan  
26 includes the health care provider with whom the person has an  
27 established care relationship and from whom he or she has received  
28 treatment within the past twelve months, the person does not have  
29 reasonable access.

30 (2) The following persons are not eligible for coverage by the  
31 pool:

32 (a) Any person having terminated coverage in the pool unless (i)  
33 twelve months have lapsed since termination, or (ii) that person can  
34 show continuous other coverage which has been involuntarily terminated  
35 for any reason other than nonpayment of premiums. However, these  
36 exclusions do not apply to eligible individuals as defined in section  
37 2741(b) of the federal health insurance portability and accountability  
38 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

1           ~~(b) ((Any person on whose behalf the pool has paid out two million~~  
2 ~~dollars in benefits;~~

3           ~~(e))~~ Inmates of public institutions and those persons who become  
4 eligible for medical assistance after June 30, 2008, as defined in RCW  
5 74.09.010. However, these exclusions do not apply to eligible  
6 individuals as defined in section 2741(b) of the federal health  
7 insurance portability and accountability act of 1996 (42 U.S.C. Sec.  
8 300gg-41(b));

9           ~~((d))~~ (c) Any person who resides in a county of the state where  
10 any carrier or insurer regulated under chapter 48.15 RCW offers to the  
11 public an individual health benefit plan other than a catastrophic  
12 health plan as defined in RCW 48.43.005 at the time of application to  
13 the pool and who does not qualify for pool coverage based upon the  
14 results of the standard health questionnaire, or pursuant to subsection  
15 (1)(a)(iv) of this section.

16           (3) When a carrier or insurer regulated under chapter 48.15 RCW  
17 begins to offer an individual health benefit plan in a county where no  
18 carrier had been offering an individual health benefit plan:

19           (a) If the health benefit plan offered is other than a catastrophic  
20 health plan as defined in RCW 48.43.005, any person enrolled in a pool  
21 plan pursuant to subsection (1)(a)(iii) of this section in that county  
22 shall no longer be eligible for coverage under that plan pursuant to  
23 subsection (1)(a)(iii) of this section, but may continue to be eligible  
24 for pool coverage based upon the results of the standard health  
25 questionnaire designated by the board and administered by the pool  
26 administrator. The pool administrator shall offer to administer the  
27 questionnaire to each person no longer eligible for coverage under  
28 subsection (1)(a)(iii) of this section within thirty days of  
29 determining that he or she is no longer eligible;

30           (b) Losing eligibility for pool coverage under this subsection (3)  
31 does not affect a person's eligibility for pool coverage under  
32 subsection (1)(a)(i), (ii), or (iv) of this section; and

33           (c) The pool administrator shall provide written notice to any  
34 person who is no longer eligible for coverage under a pool plan under  
35 this subsection (3) within thirty days of the administrator's  
36 determination that the person is no longer eligible. The notice shall:

37           (i) Indicate that coverage under the plan will cease ninety days from  
38 the date that the notice is dated; (ii) describe any other coverage



1 options, either in or outside of the pool, available to the person;  
2 (iii) describe the procedures for the administration of the standard  
3 health questionnaire to determine the person's continued eligibility  
4 for coverage under subsection (1)(a)(ii) of this section; and (iv)  
5 describe the enrollment process for the available options outside of  
6 the pool.

7 (4) The board shall ensure that an independent analysis of the  
8 eligibility standards for the pool coverage is conducted, including  
9 examining the eight percent eligibility threshold, eligibility for  
10 medicaid enrollees and other publicly sponsored enrollees, and the  
11 impacts on the pool and the state budget. The board shall report the  
12 findings to the legislature by December 1, 2007.

13 **Sec. 16.** RCW 48.41.140 and 2000 c 79 s 16 are each amended to read  
14 as follows:

15 (1) Coverage shall provide that health insurance benefits are  
16 applicable to children of the person in whose name the policy is issued  
17 including adopted and newly born natural children. Coverage shall also  
18 include necessary care and treatment of medically diagnosed congenital  
19 defects and birth abnormalities. If payment of a specific premium is  
20 required to provide coverage for the child, the policy may require that  
21 notification of the birth or adoption of a child and payment of the  
22 required premium must be furnished to the pool within thirty-one days  
23 after the date of birth or adoption in order to have the coverage  
24 continued beyond the thirty-one day period. For purposes of this  
25 subsection, a child is deemed to be adopted, and benefits are payable,  
26 when the child is physically placed for purposes of adoption under the  
27 laws of this state with the person in whose name the policy is issued;  
28 and, when the person in whose name the policy is issued assumes  
29 financial responsibility for the medical expenses of the child. For  
30 purposes of this subsection, "newly born" means, and benefits are  
31 payable, from the moment of birth.

32 (2) A pool policy shall provide that coverage of a dependent,  
33 (~~unmarried~~) person shall terminate when the person becomes  
34 (~~nineteen~~) twenty-six years of age: PROVIDED, That coverage of such  
35 person shall not terminate at age (~~nineteen~~) twenty-six while he or  
36 she is and continues to be both (a) incapable of self-sustaining  
37 employment by reason of developmental disability or physical handicap

1 and (b) chiefly dependent upon the person in whose name the policy is  
2 issued for support and maintenance, provided proof of such incapacity  
3 and dependency is furnished to the pool by the policyholder within  
4 thirty-one days of the dependent's attainment of age ((~~nineteen~~))  
5 twenty-six and subsequently as may be required by the pool but not more  
6 frequently than annually after the two-year period following the  
7 dependent's attainment of age ((~~nineteen~~)) twenty-six.

8       **Sec. 17.** RCW 48.21.157 and 2007 c 259 s 20 are each amended to  
9 read as follows:

10       Any group disability insurance contract or blanket disability  
11 insurance contract that provides coverage for a participating member's  
12 dependent must offer each participating member the option of covering  
13 any ((~~unmarried~~)) dependent under the age of ((~~twenty-five~~)) twenty-  
14 six.

15       NEW SECTION. **Sec. 18.** A new section is added to chapter 48.43 RCW  
16 to read as follows:

17       Health care sharing ministries are not health carriers as defined  
18 in RCW 48.43.005 or insurers as defined in RCW 48.01.050. For purposes  
19 of this section, "health care sharing ministry" has the same meaning as  
20 in 26 U.S.C. Sec. 5000A.

21       NEW SECTION. **Sec. 19.** Sections 10 through 12 of this act take  
22 effect January 1, 2012.

--- END ---