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HOUSE BILL 1302

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State of Washington

62nd Legislature

2011 Regular Session

By Representatives Jenkins, Lias, and Reykdal; by request of Insurance Commissioner

Read first time 01/18/11. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to health care insurance; amending RCW 48.20.435,  
2 48.21.270, 48.43.093, 48.43.530, 48.43.535, 48.44.215, 48.44.380,  
3 48.46.325, 48.46.460, 48.20.025, 48.44.017, and 48.46.062; reenacting  
4 and amending RCW 48.43.005; and providing an effective date.

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

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

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

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

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

15 (2) A conversion policy may not contain an exclusion for  
16 preexisting conditions (~~except~~) for any applicant who is under age  
17 nineteen. For policies issued to those age nineteen and older, an

1 exclusion for a preexisting condition is permitted only to the extent  
2 that a waiting period for a preexisting condition has not been  
3 satisfied under the group policy.

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

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

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

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

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

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

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

22 (a) Terms of renewability;

23 (b) Nonduplication of coverage;

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

25 (d) Definitions of terms.

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

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

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

34 (2) "Adverse benefit determination" means an adverse benefit  
35 determination as defined in 29 C.F.R. 2560.503-1 (2010), as well as any  
36 rescission of coverage, whether or not, in connection with the

1 rescission, there is an adverse effect on any particular benefit at  
2 that time.

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

5 ((+3)) (4) "Basic health plan model plan" means a health plan as  
6 required in RCW 70.47.060(2)(e).

7 ((+4)) (5) "Basic health plan services" means that schedule of  
8 covered health services, including the description of how those  
9 benefits are to be administered, that are required to be delivered to  
10 an enrollee under the basic health plan, as revised from time to time.

11 ((+5)) (6) "Catastrophic health plan" means:

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

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

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

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

1 ((+6+)) (7) "Certification" means a determination by a review  
2 organization that an admission, extension of stay, or other health care  
3 service or procedure has been reviewed and, based on the information  
4 provided, meets the clinical requirements for medical necessity,  
5 appropriateness, level of care, or effectiveness under the auspices of  
6 the applicable health benefit plan.

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

9 ((+8+)) (9) "Covered person" or "enrollee" means a person covered  
10 by a health plan including an enrollee, subscriber, policyholder,  
11 beneficiary of a group plan, or individual covered by any other health  
12 plan.

13 ((+9+)) (10) "Dependent" means, at a minimum, the enrollee's legal  
14 spouse and unmarried dependent children who qualify for coverage under  
15 the enrollee's health benefit plan.

16 ((+10+)) (11) "Emergency medical condition" means the emergent and  
17 acute onset of a symptom or symptoms, including severe pain, that would  
18 lead a prudent layperson acting reasonably to believe that a health  
19 condition exists that requires immediate medical attention, if failure  
20 to provide medical attention would result in serious impairment to  
21 bodily functions or serious dysfunction of a bodily organ or part, or  
22 would place the person's health in serious jeopardy.

23 ((+11+)) (12) "Emergency services" means ~~((otherwise covered health  
24 care services medically necessary to evaluate and treat an emergency  
25 medical condition, provided in a hospital emergency department))~~ a  
26 medical screening examination, as required under section 1867 of the  
27 social security act (42 U.S.C. 1395dd), that is within the capability  
28 of the emergency department of a hospital, including ancillary services  
29 routinely available to the emergency department to evaluate that  
30 emergency medical condition, and further medical examination and  
31 treatment, to the extent they are within the capabilities of the staff  
32 and facilities available at the hospital, as are required under section  
33 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the  
34 patient. Stabilize, with respect to an emergency medical condition,  
35 has the meaning given in section 1867(e)(3) of the social security act  
36 (42 U.S.C. 1395dd(e)(3)).

37 ((+12+)) (13) "Employee" has the same meaning given to the term, as

1 of January 1, 2008, under section 3(6) of the federal employee  
2 retirement income security act of 1974.

3 ~~((13))~~ (14) "Enrollee point-of-service cost-sharing" means  
4 amounts paid to health carriers directly providing services, health  
5 care providers, or health care facilities by enrollees and may include  
6 copayments, coinsurance, or deductibles.

7 ~~((14))~~ (15) "Final external review decision" means a  
8 determination by an independent review organization at the conclusion  
9 of an external review.

10 (16) "Final internal adverse benefit determination" means an  
11 adverse benefit determination that has been upheld by a plan or carrier  
12 at the completion of the internal appeals process, or an adverse  
13 benefit determination with respect to which the internal appeals  
14 process has been exhausted under the exhaustion rules described in RCW  
15 48.43.530 and 48.43.535.

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

24 ~~((15))~~ (18) "Health care facility" or "facility" means hospices  
25 licensed under chapter 70.127 RCW, hospitals licensed under chapter  
26 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,  
27 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes  
28 licensed under chapter 18.51 RCW, community mental health centers  
29 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment  
30 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,  
31 treatment, or surgical facilities licensed under chapter 70.41 RCW,  
32 drug and alcohol treatment facilities licensed under chapter 70.96A  
33 RCW, and home health agencies licensed under chapter 70.127 RCW, and  
34 includes such facilities if owned and operated by a political  
35 subdivision or instrumentality of the state and such other facilities  
36 as required by federal law and implementing regulations.

37 ~~((16))~~ (19) "Health care provider" or "provider" means:

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

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

6 ~~((17))~~ (20) "Health care service" means that service offered or  
7 provided by health care facilities and health care providers relating  
8 to the prevention, cure, or treatment of illness, injury, or disease.

9 ~~((18))~~ (21) "Health carrier" or "carrier" means a disability  
10 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
11 service contractor as defined in RCW 48.44.010, or a health maintenance  
12 organization as defined in RCW 48.46.020.

13 ~~((19))~~ (22) "Health plan" or "health benefit plan" means any  
14 policy, contract, or agreement offered by a health carrier to provide,  
15 arrange, reimburse, or pay for health care services except the  
16 following:

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

19 (b) Medicare supplemental health insurance governed by chapter  
20 48.66 RCW;

21 (c) Coverage supplemental to the coverage provided under chapter  
22 55, Title 10, United States Code;

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

25 (e) Disability income;

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

29 (g) Workers' compensation coverage;

30 (h) Accident only coverage;

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

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

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

36 (l) Plans deemed by the insurance commissioner to have a short-term  
37 limited purpose or duration, or to be a student-only plan that is  
38 guaranteed renewable while the covered person is enrolled as a regular

1 full-time undergraduate or graduate student at an accredited higher  
2 education institution, after a written request for such classification  
3 by the carrier and subsequent written approval by the insurance  
4 commissioner.

5 ~~((+20))~~ (23) "Material modification" means a change in the  
6 actuarial value of the health plan as modified of more than five  
7 percent but less than fifteen percent.

8 ~~((+21))~~ (24) "Preexisting condition" means any medical condition,  
9 illness, or injury that existed any time prior to the effective date of  
10 coverage.

11 ~~((+22))~~ (25) "Premium" means all sums charged, received, or  
12 deposited by a health carrier as consideration for a health plan or the  
13 continuance of a health plan. Any assessment or any "membership,"  
14 "policy," "contract," "service," or similar fee or charge made by a  
15 health carrier in consideration for a health plan is deemed part of the  
16 premium. "Premium" shall not include amounts paid as enrollee point-  
17 of-service cost-sharing.

18 ~~((+23))~~ (26) "Review organization" means a disability insurer  
19 regulated under chapter 48.20 or 48.21 RCW, health care service  
20 contractor as defined in RCW 48.44.010, or health maintenance  
21 organization as defined in RCW 48.46.020, and entities affiliated with,  
22 under contract with, or acting on behalf of a health carrier to perform  
23 a utilization review.

24 ~~((+24))~~ (27) "Small employer" or "small group" means any person,  
25 firm, corporation, partnership, association, political subdivision,  
26 sole proprietor, or self-employed individual that is actively engaged  
27 in business that employed an average of at least one but no more than  
28 fifty employees, during the previous calendar year and employed at  
29 least one employee on the first day of the plan year, is not formed  
30 primarily for purposes of buying health insurance, and in which a bona  
31 fide employer-employee relationship exists. In determining the number  
32 of employees, companies that are affiliated companies, or that are  
33 eligible to file a combined tax return for purposes of taxation by this  
34 state, shall be considered an employer. Subsequent to the issuance of  
35 a health plan to a small employer and for the purpose of determining  
36 eligibility, the size of a small employer shall be determined annually.  
37 Except as otherwise specifically provided, a small employer shall  
38 continue to be considered a small employer until the plan anniversary

1 following the date the small employer no longer meets the requirements  
2 of this definition. A self-employed individual or sole proprietor who  
3 is covered as a group of one must also: (a) Have been employed by the  
4 same small employer or small group for at least twelve months prior to  
5 application for small group coverage, and (b) verify that he or she  
6 derived at least seventy-five percent of his or her income from a trade  
7 or business through which the individual or sole proprietor has  
8 attempted to earn taxable income and for which he or she has filed the  
9 appropriate internal revenue service form 1040, schedule C or F, for  
10 the previous taxable year, except a self-employed individual or sole  
11 proprietor in an agricultural trade or business, must have derived at  
12 least fifty-one percent of his or her income from the trade or business  
13 through which the individual or sole proprietor has attempted to earn  
14 taxable income and for which he or she has filed the appropriate  
15 internal revenue service form 1040, for the previous taxable year.

16 ((+25)) (28) "Utilization review" means the prospective,  
17 concurrent, or retrospective assessment of the necessity and  
18 appropriateness of the allocation of health care resources and services  
19 of a provider or facility, given or proposed to be given to an enrollee  
20 or group of enrollees.

21 ((+26)) (29) "Wellness activity" means an explicit program of an  
22 activity consistent with department of health guidelines, such as,  
23 smoking cessation, injury and accident prevention, reduction of alcohol  
24 misuse, appropriate weight reduction, exercise, automobile and  
25 motorcycle safety, blood cholesterol reduction, and nutrition education  
26 for the purpose of improving enrollee health status and reducing health  
27 service costs.

28 **Sec. 4.** RCW 48.43.093 and 1997 c 231 s 301 are each amended to  
29 read as follows:

30 (1) (~~When conducting a review of the necessity and appropriateness~~  
31 ~~of emergency services or making a benefit determination for emergency~~  
32 ~~services~~)

33 (a) A health carrier (~~shall~~) must cover emergency services  
34 necessary to screen and stabilize a covered person if a prudent  
35 layperson acting reasonably would have believed that an emergency  
36 medical condition existed. In addition, a health carrier (~~shall~~)  
37 must not require prior authorization of such services provided prior to



1 the point of stabilization if a prudent layperson acting reasonably  
2 would have believed that an emergency medical condition existed.  
3 (~~With respect to care obtained from a nonparticipating hospital~~  
4 ~~emergency department, a health carrier shall cover emergency services~~  
5 ~~necessary to screen and stabilize a covered person if a prudent~~  
6 ~~layperson would have reasonably believed that use of a participating~~  
7 ~~hospital emergency department would result in a delay that would worsen~~  
8 ~~the emergency, or if a provision of federal, state, or local law~~  
9 ~~requires the use of a specific provider or facility. In addition, a~~  
10 ~~health carrier shall not require prior authorization of such services~~  
11 ~~provided prior to the point of stabilization if a prudent layperson~~  
12 ~~acting reasonably would have believed that an emergency medical~~  
13 ~~condition existed and that use of a participating hospital emergency~~  
14 ~~department would result in a delay that would worsen the emergency.~~

15 (b) ~~If an authorized representative of a health carrier authorizes~~  
16 ~~coverage of emergency services, the health carrier shall not~~  
17 ~~subsequently retract its authorization after the emergency services~~  
18 ~~have been provided, or reduce payment for an item or service furnished~~  
19 ~~in reliance on approval, unless the approval was based on a material~~  
20 ~~misrepresentation about the covered person's health condition made by~~  
21 ~~the provider of emergency services.)~~

22 (b) Emergency services must be provided without the need for any  
23 prior authorization determination, even if the emergency services are  
24 provided on an out-of-network basis.

25 (c) ~~Coverage of emergency services ((may be subject to applicable~~  
26 ~~copayments, coinsurance, and deductibles, and a health carrier may~~  
27 ~~impose reasonable differential cost sharing arrangements for emergency~~  
28 ~~services rendered by nonparticipating providers, if such differential~~  
29 ~~between cost sharing amounts applied to emergency services rendered by~~  
30 ~~participating provider versus nonparticipating provider does not exceed~~  
31 ~~fifty dollars. Differential cost sharing for emergency services may~~  
32 ~~not be applied when a covered person presents to a nonparticipating~~  
33 ~~hospital emergency department rather than a participating hospital~~  
34 ~~emergency department when the health carrier requires preauthorization~~  
35 ~~for postevaluation or poststabilization emergency services if:~~

36 (i) ~~Due to circumstances beyond the covered person's control, the~~  
37 ~~covered person was unable to go to a participating hospital emergency~~

1 ~~department in a timely fashion without serious impairment to the~~  
2 ~~covered person's health; or~~

3 ~~(ii) A prudent layperson possessing an average knowledge of health~~  
4 ~~and medicine would have reasonably believed that he or she would be~~  
5 ~~unable to go to a participating hospital emergency department in a~~  
6 ~~timely fashion without serious impairment to the covered person's~~  
7 ~~health.~~

8 ~~(d) If a health carrier requires preauthorization for~~  
9 ~~postevaluation or poststabilization services, the health carrier shall~~  
10 ~~provide access to an authorized representative twenty-four hours a day,~~  
11 ~~seven days a week, to facilitate review. In order for postevaluation~~  
12 ~~or poststabilization services to be covered by the health carrier, the~~  
13 ~~provider or facility must make a documented good faith effort to~~  
14 ~~contact the covered person's health carrier within thirty minutes of~~  
15 ~~stabilization, if the covered person needs to be stabilized. The~~  
16 ~~health carrier's authorized representative is required to respond to a~~  
17 ~~telephone request for preauthorization from a provider or facility~~  
18 ~~within thirty minutes. Failure of the health carrier to respond within~~  
19 ~~thirty minutes constitutes authorization for the provision of~~  
20 ~~immediately required medically necessary postevaluation and~~  
21 ~~poststabilization services, unless the health carrier documents that it~~  
22 ~~made a good faith effort but was unable to reach the provider or~~  
23 ~~facility within thirty minutes after receiving the request.~~

24 ~~(e) A health carrier shall immediately arrange for an alternative~~  
25 ~~plan of treatment for the covered person if a nonparticipating~~  
26 ~~emergency provider and health plan cannot reach an agreement on which~~  
27 ~~services are necessary beyond those immediately necessary to stabilize~~  
28 ~~the covered person consistent with state and federal laws)) must be~~  
29 ~~provided without regard to any other term or condition of the coverage~~  
30 ~~other than:~~

31 ~~(i) The exclusion or coordination of benefits;~~

32 ~~(ii) An affiliation or waiting period permitted under part 7 of the~~  
33 ~~federal employee retirement income security act, part A of Title XXVII~~  
34 ~~of the public health service act, or chapter 100 of the internal~~  
35 ~~revenue code; or~~

36 ~~(iii) Applicable cost sharing.~~

37 ~~(d) Any cost-sharing requirement expressed as a copayment amount or~~  
38 ~~coinsurance rate imposed with respect to a participant or beneficiary~~

1 for out-of-network emergency services cannot exceed the cost-sharing  
2 requirement imposed with respect to a participant or beneficiary if the  
3 services were provided in-network.

4 (i) A participant or beneficiary may be required to pay, in  
5 addition to the in-network cost sharing, the excess of the amount the  
6 out-of-network provider charges over the amount the carrier negotiated  
7 to pay to its in-network provider for the emergency service provided,  
8 excluding any in-network copayment or coinsurance imposed with respect  
9 to the participant or beneficiary.

10 (ii)(A) If there is more than one amount negotiated with in-network  
11 providers for the emergency service, the amount described under this  
12 subsection (1)(d) is the median of these amounts, excluding any in-  
13 network copayment or coinsurance imposed with respect to the  
14 participant or beneficiary.

15 (B) In determining the median described in (d)(ii)(A) of this  
16 subsection, the amount negotiated with each in-network provider is  
17 treated as a separate amount, even if the same amount is paid to more  
18 than one provider.

19 (iii) If there is no per-service amount negotiated with in-network  
20 providers such as under a capitation or other similar payment  
21 arrangement, either the amount for the emergency service is calculated  
22 using the same method the carrier generally uses to determine payments  
23 for out-of-network services, such as the usual, customary, and  
24 reasonable amount, excluding any in-network copayment or coinsurance  
25 imposed with respect to the participant or beneficiary. The amount in  
26 this subsection (1) is determined without reduction for out-of-network  
27 cost sharing that generally applies with respect to out-of-network  
28 services, or the amount for emergency service may be calculated using  
29 the amount that would be paid under medicare, part A or part B of Title  
30 XVIII of the social security act, 42 U.S.C. 1395 et seq., for the  
31 emergency service, excluding any in-network copayment or coinsurance  
32 imposed with respect to the participant or beneficiary.

33 (iv) Any cost-sharing requirement other than a copayment or  
34 coinsurance requirement, such as a deductible or out-of-pocket maximum,  
35 may be imposed with respect to emergency services provided out of  
36 network if the cost-sharing requirement generally applies to out-of-  
37 network benefits. A deductible may be imposed with respect to out-of-  
38 network emergency services only as part of a deductible that generally

1 applies to out-of-network benefits. If an out-of-pocket maximum  
2 generally applies to out-of-network benefits, that out-of-pocket  
3 maximum must apply to out-of-network emergency services.

4 (2) Nothing in this section is to be construed as prohibiting the  
5 health carrier from requiring notification within the time frame  
6 specified in the contract for inpatient admission or as soon thereafter  
7 as medically possible but no less than twenty-four hours. Nothing in  
8 this section is to be construed as preventing the health carrier from  
9 reserving the right to require transfer of a hospitalized covered  
10 person upon stabilization. Follow-up care that is a direct result of  
11 the emergency must be obtained in accordance with the health plan's  
12 usual terms and conditions of coverage. All other terms and conditions  
13 of coverage may be applied to emergency services.

14 **Sec. 5.** RCW 48.43.530 and 2000 c 5 s 10 are each amended to read  
15 as follows:

16 (1) Each carrier that offers a health plan must have a fully  
17 operational, comprehensive grievance process that complies with the  
18 requirements of this section and any rules adopted by the commissioner  
19 to implement this section. For the purposes of this section, the  
20 commissioner shall consider grievance process standards adopted by  
21 national managed care accreditation organizations and state agencies  
22 that purchase managed health care services, and as approved by the  
23 United States department of health and human services or the United  
24 States department of labor.

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

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

35 (4) Each carrier must process as an appeal an enrollee's written or  
36 oral request that the carrier reconsider: (a) Its resolution of a  
37 complaint made by an enrollee; or (b) its decision to deny, modify,

1 reduce, or terminate payment, coverage, authorization, or provision of  
2 health care services or benefits, including the admission to, or  
3 continued stay in, a health care facility. A carrier must not require  
4 that an enrollee file a complaint prior to seeking appeal of a decision  
5 under (b) of this subsection.

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

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

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

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

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

19 (e) Consider information submitted by the enrollee;

20 (f) Investigate and resolve the appeal; and

21 (g) Provide written notice of its resolution of the appeal to the  
22 enrollee and, with the permission of the enrollee, to the enrollee's  
23 providers. The written notice must explain the carrier's decision and  
24 the supporting coverage or clinical reasons and the enrollee's right to  
25 request independent review of the carrier's decision under RCW  
26 48.43.535.

27 (6) Written notice required by subsection (3) of this section must  
28 explain in a culturally and linguistically appropriate manner that  
29 complies with the standards established by the United States department  
30 of health and human services or the United States department of labor:

31 (a) The carrier's decision and the supporting coverage or clinical  
32 reasons; (~~and~~)

33 (b) The carrier's appeal process, including information, as  
34 appropriate, about how to exercise the enrollee's rights to obtain a  
35 second opinion, and how to continue receiving services as provided in  
36 this section;

37 (c) Sufficient information to identify the claim involved,

1 including the date of service, the health care provider, the claim  
2 amount, if applicable, the diagnosis code and its corresponding  
3 meaning, and the treatment code and its corresponding meaning; and

4 (d) The reason or reasons for the adverse benefit determination or  
5 final internal adverse benefit determination, including the denial code  
6 and its corresponding meaning, as well as the description of the plan's  
7 or carrier's standard that was used in denying the claim. When the  
8 decision is a final internal adverse benefit determination, the  
9 description must include a discussion of the decision.

10 (7) When an enrollee requests that the carrier reconsider its  
11 decision to modify, reduce, or terminate an otherwise covered health  
12 service that an enrollee is receiving through the health plan and the  
13 carrier's decision is based upon a finding that the health service, or  
14 level of health service, is no longer medically necessary or  
15 appropriate, the carrier must continue to provide that health service  
16 until the appeal is resolved. If the resolution of the appeal or any  
17 review sought by the enrollee under RCW 48.43.535 affirms the carrier's  
18 decision, the enrollee may be responsible for the cost of this  
19 continued health service.

20 (8) Each carrier must provide a clear explanation of the grievance  
21 process upon request, upon enrollment to new enrollees, and annually to  
22 enrollees and subcontractors. The information provided must include  
23 information for any applicable office of health insurance consumer  
24 assistance or ombudsman established under section 2793 of the public  
25 health service act to assist individuals with the internal claims and  
26 appeals and external review processes.

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

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

35 **Sec. 6.** RCW 48.43.535 and 2000 c 5 s 11 are each amended to read  
36 as follows:

37 (1) There is a need for a process for the fair consideration of

1 disputes relating to decisions by carriers that offer a health plan to  
2 deny, modify, reduce, or terminate coverage of or payment for health  
3 care services for an enrollee.

4 (2) An enrollee may seek review by a certified independent review  
5 organization of a carrier's decision to deny, modify, reduce, or  
6 terminate coverage of or payment for a health care service, after  
7 exhausting the carrier's grievance process and receiving a decision  
8 that is unfavorable to the enrollee, or after the carrier has exceeded  
9 the timelines for grievances provided in RCW 48.43.530, without good  
10 cause and without reaching a decision.

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

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

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

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

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

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

34 (5) Claimants must be provided with at least five business days to  
35 submit to the independent review organization in writing additional  
36 information that the independent review organization must consider when  
37 conducting the external review. The independent review organization

1 must forward any additional information submitted by a claimant to the  
2 plan or carrier within one business day of receipt by the independent  
3 review organization.

4 (6) The medical reviewers from a certified independent review  
5 organization will make determinations regarding the medical necessity  
6 or appropriateness of, and the application of health plan coverage  
7 provisions to, health care services for an enrollee. The medical  
8 reviewers' determinations must be based upon their expert medical  
9 judgment, after consideration of relevant medical, scientific, and  
10 cost-effectiveness evidence, and medical standards of practice in the  
11 state of Washington. Except as provided in this subsection, the  
12 certified independent review organization must ensure that  
13 determinations are consistent with the scope of covered benefits as  
14 outlined in the medical coverage agreement. Medical reviewers may  
15 override the health plan's medical necessity or appropriateness  
16 standards if the standards are determined upon review to be  
17 unreasonable or inconsistent with sound, evidence-based medical  
18 practice.

19 ((+6)) (7) Once a request for an independent review determination  
20 has been made, the independent review organization must proceed to a  
21 final determination, unless requested otherwise by both the carrier and  
22 the enrollee or the enrollee's representative.

23 ((+7)) (a) The independent review organization must provide  
24 written notice to the claimant and the plan or carrier of its decision  
25 to uphold or reverse the adverse benefit determination or internal  
26 adverse benefit determination within no more than forty-five days after  
27 its receipt of the request for external review.

28 (b) A claimant or carrier may request an expedited external review  
29 if the adverse benefit determination or internal adverse benefit  
30 determination concerns an admission, availability of care, continued  
31 stay, or health care service for which the claimant received emergency  
32 services but has not been discharged from a facility; or involves a  
33 medical condition for which the standard external review time frame of  
34 forty-five days would seriously jeopardize the life or health of the  
35 claimant or jeopardize the claimant's ability to regain maximum  
36 function. The independent review organization must make its decision  
37 to uphold or reverse the adverse benefit determination or final  
38 internal adverse benefit determination and notify the claimant and the



1 carrier or plan of the determination as expeditiously as possible but  
2 within not more than seventy-two hours after the receipt of the request  
3 for expedited external review. If the notice is not in writing, the  
4 independent review organization must provide written confirmation of  
5 the decision within forty-eight hours after the date of the notice of  
6 the decision.

7 (c) For claims involving experimental or investigational  
8 treatments, the internal review organization must ensure that adequate  
9 clinical and scientific experience and protocols are taken into account  
10 as part of the external review process.

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

14 ~~((+8))~~ (9) When an enrollee requests independent review of a  
15 dispute under this section, and the dispute involves a carrier's  
16 decision to modify, reduce, or terminate an otherwise covered health  
17 service that an enrollee is receiving at the time the request for  
18 review is submitted and the carrier's decision is based upon a finding  
19 that the health service, or level of health service, is no longer  
20 medically necessary or appropriate, the carrier must continue to  
21 provide the health service if requested by the enrollee until a  
22 determination is made under this section. If the determination affirms  
23 the carrier's decision, the enrollee may be responsible for the cost of  
24 the continued health service.

25 ~~((+9))~~ (10) Each certified independent review organization must  
26 maintain written records and make them available upon request to the  
27 commissioner.

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

32 ~~((+10))~~ (12)(a) The commissioner shall adopt rules to implement  
33 this section after considering relevant standards adopted by national  
34 managed care accreditation organizations and the national association  
35 of insurance commissioners.

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

1           **Sec. 7.** RCW 48.44.215 and 2007 c 259 s 21 are each amended to read  
2 as follows:

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

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

11           **Sec. 8.** RCW 48.44.380 and 1984 c 190 s 7 are each amended to read  
12 as follows:

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

15           (2) A conversion contract may not contain an exclusion for  
16 preexisting conditions (~~(except)~~) for any applicant who is under age  
17 nineteen. For policies issued to those age nineteen and older, an  
18 exclusion for a preexisting condition is permitted only to the extent  
19 that a waiting period for a preexisting condition has not been  
20 satisfied under the group contract.

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

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

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

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

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

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

36           (6) The commissioner shall adopt rules to establish specific

1 standards for conversion contract provisions. These rules may include  
2 but are not limited to:

- 3 (a) Terms of renewability;
- 4 (b) Nonduplication of coverage;
- 5 (c) Benefit limitations, exceptions, and reductions; and
- 6 (d) Definitions of terms.

7 **Sec. 9.** RCW 48.46.325 and 2007 c 259 s 22 are each amended to read  
8 as follows:

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

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

17 **Sec. 10.** RCW 48.46.460 and 1984 c 190 s 10 are each amended to  
18 read as follows:

19 (1) A health maintenance organization must offer a conversion  
20 agreement for comprehensive health care services and shall not require  
21 proof of insurability as a condition for issuance of the conversion  
22 agreement.

23 (2) A conversion agreement may not contain an exclusion for  
24 preexisting conditions (~~except~~) for an applicant who is under age  
25 nineteen. For policies issued to those age nineteen and older, an  
26 exclusion for a preexisting condition is permitted only to the extent  
27 that a waiting period for a preexisting condition has not been  
28 satisfied under the group agreement.

29 (3) A conversion agreement need not provide benefits identical to  
30 those provided under the group agreement. The conversion agreement may  
31 contain provisions requiring the person covered by the conversion  
32 agreement to pay reasonable deductibles and copayments, except for  
33 preventive service benefits as defined in 45 C.F.R. 147.130 (2010),  
34 implementing sections 2701 through 2763, 2791, and 2792 of the public  
35 health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and  
36 300gg-92), as amended.

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

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

6 (a) Terms of renewability;

7 (b) Nonduplication of coverage;

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

9 (d) Definitions of terms.

10 **Sec. 11.** RCW 48.20.025 and 2008 c 303 s 4 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 insurer of health care services,  
15 as defined in RCW 48.43.005, provided to a policyholder or paid to or  
16 on behalf of the policyholder in accordance with the terms of a health  
17 benefit plan, as defined in RCW 48.43.005. This includes capitation  
18 payments or other similar payments made to providers for the purpose of  
19 paying for health care services for a policyholder.

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

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

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

35 (e) "Incurred claims expense" means claims paid during the  
36 applicable period plus any increase, or less any decrease, in the  
37 claims reserves.

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

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

5 (2) An insurer must file supporting documentation of its method of  
6 determining the rates charged for its individual health benefit plans.  
7 At a minimum, the insurer must provide the following supporting  
8 documentation:

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

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

13 (c) The percentage of premium attributable in aggregate for  
14 nonclaims expenses used to determine the adjusted community rates  
15 charged; and

16 (d) A certification by a member of the American academy of  
17 actuaries, or other person approved by the commissioner, that the  
18 adjusted community rate charged can be reasonably expected to result in  
19 a loss ratio that meets or exceeds the loss ratio standard of  
20 seventy-four percent, minus the premium tax rate applicable to the  
21 insurer's individual health benefit plans under RCW 48.14.020.

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

33 ~~(a) At the expiration of a thirty day period beginning with the~~  
34 ~~date the filing is received by the commissioner, the filing shall be~~  
35 ~~deemed approved unless prior thereto the commissioner contests the~~  
36 ~~calculation of the actual loss ratio.~~

37 ~~(b) If the commissioner contests the calculation of the actual loss~~

1 ~~ratio, the commissioner shall state in writing the grounds for~~  
2 ~~contesting the calculation to the insurer.~~

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

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

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

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

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

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

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

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

1       **Sec. 12.** RCW 48.44.017 and 2008 c 303 s 5 are each amended to read  
2 as follows:

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

5       (a) "Claims" means the cost to the health care service contractor  
6 of health care services, as defined in RCW 48.43.005, provided to a  
7 contract holder or paid to or on behalf of a contract holder in  
8 accordance with the terms of a health benefit plan, as defined in RCW  
9 48.43.005. This includes capitation payments or other similar payments  
10 made to providers for the purpose of paying for health care services  
11 for an enrollee.

12       (b) "Claims reserves" means: (i) The liability for claims which  
13 have been reported but not paid; (ii) the liability for claims which  
14 have not been reported but which may reasonably be expected; (iii)  
15 active life reserves; and (iv) additional claims reserves whether for  
16 a specific liability purpose or not.

17       (c) "Declination rate" for a health care service contractor means  
18 the percentage of the total number of applicants for individual health  
19 benefit plans received by that health care service contractor in the  
20 aggregate in the applicable year which are not accepted for enrollment  
21 by that health care service contractor based on the results of the  
22 standard health questionnaire administered pursuant to RCW  
23 48.43.018(2)(a).

24       (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
25 plus any rate credits or recoupments less any refunds, for the  
26 applicable period, whether received before, during, or after the  
27 applicable period.

28       (e) "Incurred claims expense" means claims paid during the  
29 applicable period plus any increase, or less any decrease, in the  
30 claims reserves.

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

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

35       (2) A health care service contractor must file supporting  
36 documentation of its method of determining the rates charged for its  
37 individual contracts. At a minimum, the health care service contractor  
38 must provide the following supporting documentation:

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

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

6 (c) The percentage of premium attributable in aggregate for  
7 nonclaims expenses used to determine the adjusted community rates  
8 charged; and

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

15 ~~((3) By the last day of May each year any health care service~~  
16 ~~contractor issuing or renewing individual health benefit plans in this~~  
17 ~~state during the preceding calendar year shall file for review by the~~  
18 ~~commissioner supporting documentation of its actual loss ratio and its~~  
19 ~~actual declination rate for its individual health benefit plans offered~~  
20 ~~or renewed in this state in aggregate for the preceding calendar year.~~  
21 ~~The filing shall include aggregate earned premiums, aggregate incurred~~  
22 ~~claims, and a certification by a member of the American academy of~~  
23 ~~actuaries, or other person approved by the commissioner, that the~~  
24 ~~actual loss ratio has been calculated in accordance with accepted~~  
25 ~~actuarial principles.~~

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

30 ~~(b) If the commissioner contests the calculation of the actual loss~~  
31 ~~ratio, the commissioner shall state in writing the grounds for~~  
32 ~~contesting the calculation to the health care service contractor.~~

33 ~~(c) Any dispute regarding the calculation of the actual loss ratio~~  
34 ~~shall upon written demand of either the commissioner or the health care~~  
35 ~~service contractor be submitted to hearing under chapters 48.04 and~~  
36 ~~34.05 RCW.~~

37 ~~(4) If the actual loss ratio for the preceding calendar year is~~



1 less than the loss ratio standard established in subsection (5) of this  
2 section, a remittance is due and the following shall apply:

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

7 (b) The remittance to the Washington state health insurance pool is  
8 the percentage calculated in (a) of this subsection, multiplied by the  
9 premium earned from each enrollee in the previous calendar year.  
10 Interest shall be added to the remittance due at a five percent annual  
11 rate calculated from the end of the calendar year for which the  
12 remittance is due to the date the remittance is made.

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

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

20 (5) The loss ratio applicable to this section shall be the  
21 percentage set forth in the following schedule that correlates to the  
22 health care service contractor's actual declination rate in the  
23 preceding year, minus the premium tax rate applicable to the health  
24 care service contractor's individual health benefit plans under RCW  
25 48.14.0201.

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

31 **Sec. 13.** RCW 48.46.062 and 2008 c 303 s 6 are each amended to read  
32 as follows:

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

35 (a) "Claims" means the cost to the health maintenance organization  
36 of health care services, as defined in RCW 48.43.005, provided to an

1 enrollee or paid to or on behalf of the enrollee in accordance with the  
2 terms of a health benefit plan, as defined in RCW 48.43.005. This  
3 includes capitation payments or other similar payments made to  
4 providers for the purpose of paying for health care services for an  
5 enrollee.

6 (b) "Claims reserves" means: (i) The liability for claims which  
7 have been reported but not paid; (ii) the liability for claims which  
8 have not been reported but which may reasonably be expected; (iii)  
9 active life reserves; and (iv) additional claims reserves whether for  
10 a specific liability purpose or not.

11 (c) "Declination rate" for a health maintenance organization means  
12 the percentage of the total number of applicants for individual health  
13 benefit plans received by that health maintenance organization in the  
14 aggregate in the applicable year which are not accepted for enrollment  
15 by that health maintenance organization based on the results of the  
16 standard health questionnaire administered pursuant to RCW  
17 48.43.018(2)(a).

18 (d) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
19 plus any rate credits or recoupments less any refunds, for the  
20 applicable period, whether received before, during, or after the  
21 applicable period.

22 (e) "Incurred claims expense" means claims paid during the  
23 applicable period plus any increase, or less any decrease, in the  
24 claims reserves.

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

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

29 (2) A health maintenance organization must file supporting  
30 documentation of its method of determining the rates charged for its  
31 individual agreements. At a minimum, the health maintenance  
32 organization must provide the following supporting documentation:

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

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

1 (c) The percentage of premium attributable in aggregate for  
2 nonclaims expenses used to determine the adjusted community rates  
3 charged; and

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

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

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

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

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

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

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

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

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

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

14       ~~(5) The loss ratio applicable to this section shall be the~~  
15 ~~percentage set forth in the following schedule that correlates to the~~  
16 ~~health maintenance organization's actual declination rate in the~~  
17 ~~preceding year, minus the premium tax rate applicable to the health~~  
18 ~~maintenance organization's individual health benefit plans under RCW~~  
19 ~~48.14.0201.~~

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

25       NEW SECTION.   **Sec. 14.**   Sections 11 through 13 of this act take  
26 effect January 1, 2012.

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