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**SUBSTITUTE HOUSE BILL 2666**

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**State of Washington                      60th Legislature                      2008 Regular Session**

**By** House Health Care & Wellness (originally sponsored by Representatives Morrell, Cody, McCoy, Green, Hunt, Wallace, Pedersen, Moeller, McIntire, Barlow, Conway, Simpson, and Darneille)

READ FIRST TIME 02/04/08.

1            AN ACT Relating to long-term care insurance; amending RCW 48.84.010  
2 and 48.85.010; reenacting and amending RCW 48.43.005; adding a new  
3 chapter to Title 48 RCW; prescribing penalties; and providing an  
4 effective date.

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

6            NEW SECTION.    **Sec. 1.** The intent of this chapter is to promote the  
7 public interest, support the availability of long-term care coverage,  
8 establish standards for long-term care coverage, facilitate public  
9 understanding and comparison of long-term care contract benefits,  
10 protect persons insured under long-term care insurance policies and  
11 certificates, protect applicants for long-term care policies from  
12 unfair or deceptive sales or enrollment practices, and provide for  
13 flexibility and innovation in the development of long-term care  
14 insurance coverage.

15            NEW SECTION.    **Sec. 2.** This chapter applies to all long-term care  
16 insurance policies, contracts, or riders delivered or issued for  
17 delivery in this state on or after January 1, 2009. This chapter does  
18 not supersede the obligations of entities subject to this chapter to

1 comply with other applicable laws to the extent that they do not  
2 conflict with this chapter, except that laws and regulations designed  
3 and intended to apply to medicare supplement insurance policies shall  
4 not be applied to long-term care insurance.

5 (1) Coverage advertised, marketed, or offered as long-term care  
6 insurance shall comply with the provisions of this chapter. Any  
7 coverage, policy, or rider advertised, marketed, or offered as long-  
8 term care or nursing home insurance shall comply with the provisions of  
9 this chapter.

10 (2) Individual and group long-term care contracts issued prior to  
11 January 1, 2009, remain governed by chapter 48.84 RCW and rules adopted  
12 thereunder.

13 (3) This chapter is not intended to prohibit approval of long-term  
14 care funded through life insurance.

15 NEW SECTION. **Sec. 3.** The definitions in this section apply  
16 throughout this chapter unless the context clearly requires otherwise.

17 (1) "Applicant" means: (a) In the case of an individual long-term  
18 care insurance policy, the person who seeks to contract for benefits;  
19 and (b) in the case of a group long-term care insurance policy, the  
20 proposed certificate holder.

21 (2) "Certificate" includes any certificate issued under a group  
22 long-term care insurance policy that has been delivered or issued for  
23 delivery in this state.

24 (3) "Commissioner" means the insurance commissioner of Washington  
25 state.

26 (4) "Issuer" includes insurance companies, fraternal benefit  
27 societies, health care service contractors, health maintenance  
28 organizations, or other entity delivering or issuing for delivery any  
29 long-term care insurance policy, contract, or rider.

30 (5) "Long-term care insurance" means an insurance policy, contract,  
31 or rider that is advertised, marketed, offered, or designed to provide  
32 coverage for at least twelve consecutive months for a covered person.  
33 Long-term care insurance maybe on an expense incurred, indemnity,  
34 prepaid, or other basis, for one or more necessary or medically  
35 necessary diagnostic, preventive, therapeutic, rehabilitative,  
36 maintenance, or personal care services, provided in a setting other  
37 than an acute care unit of a hospital. Long-term care insurance

1 includes any policy, contract, or rider that provides for payment of  
2 benefits based upon cognitive impairment or the loss of functional  
3 capacity.

4 (a) Long-term care insurance includes group and individual  
5 annuities and life insurance policies or riders that provide directly  
6 or supplement long-term care insurance. However, long-term care  
7 insurance does not include life insurance policies that: (i)  
8 Accelerate the death benefit specifically for one or more of the  
9 qualifying events of terminal illness, medical conditions requiring  
10 extraordinary medical intervention, or permanent institutional  
11 confinement; (ii) provide the option of a lump-sum payment for those  
12 benefits; and (iii) do not condition the benefits or the eligibility  
13 for the benefits upon the receipt of long-term care.

14 (b) Long-term care insurance also includes qualified long-term care  
15 insurance contracts.

16 (c) Long-term care insurance does not include any insurance policy,  
17 contract, or rider that is offered primarily to provide coverage for  
18 basic medicare supplement, basic hospital expense, basic medical-  
19 surgical expense, hospital confinement indemnity, major medical  
20 expense, disability income, related income, asset protection, accident  
21 only, specified disease, specified accident, or limited benefit health.

22 (6) "Group long-term care insurance" means a long-term care  
23 insurance policy or contract that is delivered or issued for delivery  
24 in this state and is issued to:

25 (a) One or more employers; one or more labor organizations; or a  
26 trust or the trustees of a fund established by one or more employers or  
27 labor organizations for current or former employees, current or former  
28 members of the labor organizations, or a combination of current and  
29 former employees or members, or a combination of such employers, labor  
30 organizations, trusts, or trustees; or

31 (b) A professional, trade, or occupational association for its  
32 members or former or retired members, if the association:

33 (i) Is composed of persons who are or were all actively engaged in  
34 the same profession, trade, or occupation; and

35 (ii) Has been maintained in good faith for purposes other than  
36 obtaining insurance; or

37 (c)(i) An association, trust, or the trustees of a fund  
38 established, created, or maintained for the benefit of members of one

1 or more associations. Before advertising, marketing, or offering long-  
2 term care coverage in this state, the association or associations, or  
3 the insurer of the association or associations, must file evidence with  
4 the commissioner that the association or associations have at the time  
5 of such filing at least one hundred persons who are members and that  
6 the association or associations have been organized and maintained in  
7 good faith for purposes other than that of obtaining insurance; have  
8 been in active existence for at least one year; and have a constitution  
9 and bylaws that provide that:

10 (A) The association or associations hold regular meetings at least  
11 annually to further the purposes of the members;

12 (B) Except for credit unions, the association or associations  
13 collect dues or solicit contributions from members; and

14 (C) The members have voting privileges and representation on the  
15 governing board and committees of the association.

16 (ii) Thirty days after filing the evidence in accordance with this  
17 section, the association or associations will be deemed to have  
18 satisfied the organizational requirements, unless the commissioner  
19 makes a finding that the association or associations do not satisfy  
20 those organizational requirements.

21 (d) A group other than as described in (a), (b), or (c) of this  
22 subsection subject to a finding by the commissioner that:

23 (i) The issuance of the group policy is not contrary to the best  
24 interest of the public;

25 (ii) The issuance of the group policy would result in economies of  
26 acquisition or administration; and

27 (iii) The benefits are reasonable in relation to the premiums  
28 charged.

29 (7) "Policy" includes a document such as an insurance policy,  
30 contract, subscriber agreement, rider, or endorsement delivered or  
31 issued for delivery in this state by an insurer, fraternal benefit  
32 society, health care service contractor, health maintenance  
33 organization, or any similar entity authorized by the insurance  
34 commissioner to transact the business of long-term care insurance.

35 (8) "Qualified long-term care insurance contract" or "federally  
36 tax-qualified long-term care insurance contract" means:

37 (a) An individual or group insurance contract that meets the

1 requirements of section 7702B(b) of the internal revenue code of 1986,  
2 as amended; or

3 (b) The portion of a life insurance contract that provides long-  
4 term care insurance coverage by rider or as part of the contract and  
5 that satisfies the requirements of sections 7702B(b) and (e) of the  
6 internal revenue code of 1986, as amended.

7 NEW SECTION. **Sec. 4.** A group long-term care insurance policy may  
8 not be offered to a resident of this state under a group policy issued  
9 in another state to a group described in section 3(6)(d) of this act,  
10 unless this state or another state having statutory and regulatory  
11 long-term care insurance requirements substantially similar to those  
12 adopted in this state has made a determination that such requirements  
13 have been met.

14 NEW SECTION. **Sec. 5.** (1) A long-term care insurance policy or  
15 certificate may not define "preexisting condition" more restrictively  
16 than as a condition for which medical advice or treatment was  
17 recommended by or received from a provider of health care services,  
18 within six months preceding the effective date of coverage of an  
19 insured person, unless the policy or certificate applies to group long-  
20 term care insurance under section 3(6) (a), (b), or (c) of this act.

21 (2) A long-term care insurance policy or certificate may not  
22 exclude coverage for a loss or confinement that is the result of a  
23 preexisting condition unless the loss or confinement begins within six  
24 months following the effective date of coverage of an insured person,  
25 unless the policy or certificate applies to a group as defined in  
26 section 3(6)(a) of this act.

27 (3) The commissioner may extend the limitation periods for specific  
28 age group categories in specific policy forms upon finding that the  
29 extension is in the best interest of the public.

30 (4) An issuer may use an application form designed to elicit the  
31 complete health history of an applicant and underwrite in accordance  
32 with that issuer's established underwriting standards, based on the  
33 answers on that application. Unless otherwise provided in the policy  
34 or certificate and regardless of whether it is disclosed on the  
35 application, a preexisting condition need not be covered until the  
36 waiting period expires.

1 (5) A long-term care insurance policy or certificate may not  
2 exclude or use waivers or riders to exclude, limit, or reduce coverage  
3 or benefits for specifically named or described preexisting diseases or  
4 physical conditions beyond the waiting period.

5 NEW SECTION. **Sec. 6.** No long-term care insurance policy may:

6 (1) Be canceled, nonrenewed, or otherwise terminated on the grounds  
7 of the age or the deterioration of the mental or physical health of the  
8 insured individual or certificate holder;

9 (2) Contain a provision establishing a new waiting period in the  
10 event existing coverage is converted to or replaced by a new or other  
11 form within the same company, except with respect to an increase in  
12 benefits voluntarily selected by the insured individual or group  
13 policyholder;

14 (3) Provide coverage for skilled nursing care only or provide  
15 significantly more coverage for skilled care in a facility than  
16 coverage for lower levels of care;

17 (4) Condition eligibility for any benefits on a prior  
18 hospitalization requirement;

19 (5) Condition eligibility for benefits provided in an institutional  
20 care setting on the receipt of a higher level of institutional care;

21 (6) Condition eligibility for any benefits other than waiver of  
22 premium, postconfinement, postacute care, or recuperative benefits on  
23 a prior institutionalization requirement;

24 (7) Include a postconfinement, postacute care, or recuperative  
25 benefit unless:

26 (a) Such requirement is clearly labeled in a separate paragraph of  
27 the policy or certificate entitled "Limitations or Conditions on  
28 Eligibility for Benefits;" and

29 (b) Such limitations or conditions specify any required number of  
30 days of preconfinement or postconfinement;

31 (8) Condition eligibility for noninstitutional benefits on the  
32 prior receipt of institutional care;

33 (9) A long-term care insurance policy or certificate may be field-  
34 issued if the compensation to the field issuer is not based on the  
35 number of policies or certificates issued. For purposes of this  
36 section, "field-issued" means a policy or certificate issued by a

1 producer or a third-party administrator of the policy pursuant to the  
2 underwriting authority by an issuer and using the issuer's underwriting  
3 guidelines.

4 NEW SECTION. **Sec. 7.** (1) Long-term care insurance applicants may  
5 return a policy or certificate for any reason within thirty days after  
6 its delivery and to have the premium refunded.

7 (2) All long-term care insurance policies and certificates shall  
8 have a notice prominently printed on or attached to the first page of  
9 the policy stating that the applicant may return the policy or  
10 certificate within thirty days after its delivery and to have the  
11 premium refunded.

12 (3) Refunds or denials of applications must be made within thirty  
13 days of the return or denial.

14 (4) This section shall not apply to certificates issued pursuant to  
15 a policy issued to a group defined in section 3(6)(a) of this act.

16 NEW SECTION. **Sec. 8.** (1) An outline of coverage must be delivered  
17 to a prospective applicant for long-term care insurance at the time of  
18 initial solicitation through means that prominently direct the  
19 attention of the recipient to the document and its purpose.

20 (a) The commissioner must prescribe a standard format, including  
21 style, arrangement, overall appearance, and the content of an outline  
22 of coverage.

23 (b) When an insurance producer makes a solicitation in person, he  
24 or she must deliver an outline of coverage before presenting an  
25 application or enrollment form.

26 (c) In a direct response solicitation, the outline of coverage must  
27 be presented with an application or enrollment form.

28 (d) If a policy is issued to a group as defined in section 3(6)(a)  
29 of this act, an outline of coverage is not required to be delivered, if  
30 the information that the commissioner requires to be included in the  
31 outline of coverage is in other materials relating to enrollment. Upon  
32 request, any such materials must be made available to the commissioner.

33 (2) If an issuer approves an application for a long-term care  
34 insurance contract or certificate, the issuer must deliver the contract  
35 or certificate of insurance to the applicant within thirty days after  
36 the date of approval. A policy summary must be delivered with an

1 individual life insurance policy that provides long-term care benefits  
2 within the policy or by rider. In a direct response solicitation, the  
3 issuer must deliver the policy summary, upon request, before delivery  
4 of the policy, if the applicant requests a summary.

5 (a) The policy summary shall include:

6 (i) An explanation of how the long-term care benefit interacts with  
7 other components of the policy, including deductions from any  
8 applicable death benefits;

9 (ii) An illustration of the amount of benefits, the length of  
10 benefits, and the guaranteed lifetime benefits if any, for each covered  
11 person;

12 (iii) Any exclusions, reductions, and limitations on benefits of  
13 long-term care;

14 (iv) A statement that any long-term care inflation protection  
15 option required by section 12 of this act is not available under this  
16 policy; and

17 (v) If applicable to the policy type, the summary must also  
18 include:

19 (A) A disclosure of the effects of exercising other rights under  
20 the policy;

21 (B) A disclosure of guarantees related to long-term care costs of  
22 insurance charges; and

23 (C) Current and projected maximum lifetime benefits.

24 (b) The provisions of the policy summary may be incorporated into  
25 a basic illustration required under chapter 48.23A RCW, or into the  
26 policy summary which is required under rules adopted by the  
27 commissioner.

28 NEW SECTION. **Sec. 9.** If a long-term care benefit funded through  
29 a life insurance policy by the acceleration of the death benefit is in  
30 benefit payment status, a monthly report must be provided to the  
31 policyholder. The report must include:

32 (1) A record of all long-term care benefits paid out during the  
33 month;

34 (2) An explanation of any changes in the policy resulting from  
35 paying the long-term care benefits, such as a change in the death  
36 benefit or cash values; and

37 (3) The amount of long-term care benefits that remain to be paid.



1        NEW SECTION.    **Sec. 10.** All long-term care denials must be made  
2 within sixty days after receipt of a written request made by a  
3 policyholder or certificate holder, or his or her representative. All  
4 denials of long-term care claims by the issuer must provide a written  
5 explanation of the reasons for the denial and make available to the  
6 policyholder or certificate holder all information directly related to  
7 the denial.

8        NEW SECTION.    **Sec. 11.** (1) An issuer may rescind a long-term care  
9 insurance policy or certificate or deny an otherwise valid long-term  
10 care insurance claim if:

11        (a) A policy or certificate has been in force for less than six  
12 months and upon a showing of misrepresentation that is material to the  
13 acceptance for coverage; or

14        (b) A policy or certificate that has been in force for at least six  
15 months but less than two years, upon a showing of misrepresentation  
16 that is both material to the acceptance for coverage and that pertains  
17 to the condition for which benefits are sought.

18        (2) After a policy or certificate has been in force for two years  
19 it is not contestable upon the grounds of misrepresentation alone.  
20 Such a policy or certificate may be contested only upon a showing that  
21 the insured knowingly and intentionally misrepresented relevant facts  
22 relating to the insured's health.

23        (3) An issuer's payments for benefits under a long-term care  
24 insurance policy or certificate may not be recovered by the issuer if  
25 the policy or certificate is rescinded.

26        (4) This section does not apply to the remaining death benefit of  
27 a life insurance policy that accelerates benefits for long-term care  
28 that are governed by RCW 48.23.050 the state's life insurance  
29 incontestability clause. In all other situations, this section shall  
30 apply to life insurance policies that accelerate benefits for long-term  
31 care.

32        NEW SECTION.    **Sec. 12.** (1) The commissioner must establish minimum  
33 standards for inflation protection features.

34        (2) An issuer must comply with the rules adopted by the  
35 commissioner that establish minimum standards for inflation protection  
36 features.

1        NEW SECTION.    **Sec. 13.**    (1) Except as provided by this section, a  
2 long-term care insurance policy may not be delivered or issued for  
3 delivery in this state unless the policyholder or certificate holder  
4 has been offered the option of purchasing a policy or certificate that  
5 includes a nonforfeiture benefit. The offer of a nonforfeiture benefit  
6 may be in the form of a rider that is attached to the policy. If a  
7 policyholder or certificate holder declines the nonforfeiture benefit,  
8 the issuer must provide a contingent benefit upon lapse that is  
9 available for a specified period of time following a substantial  
10 increase in premium rates.

11        (2) If a group long-term care insurance policy is issued, the offer  
12 required in subsection (1) of this section must be made to the group  
13 policyholder. However, if the policy is issued as group long-term care  
14 insurance as defined in section 3(6)(d) of this act other than to a  
15 continuing care retirement community or other similar entity, the  
16 offering shall be made to each proposed certificate holder.

17        (3) The commissioner must adopt rules specifying the type or types  
18 of nonforfeiture benefits to be offered as part of long-term care  
19 insurance policies and certificates, the standards for nonforfeiture  
20 benefits, and the rules regarding contingent benefit upon lapse,  
21 including a determination of the specified period of time during which  
22 a contingent benefit upon lapse will be available and the substantial  
23 premium rate increase that triggers a contingent benefit upon lapse.

24        NEW SECTION.    **Sec. 14.**    (1) A person may not sell, solicit, or  
25 negotiate long-term care insurance unless he or she is licensed as an  
26 insurance producer and has successfully completed a one-time training  
27 course by or before July 1, 2009, and successfully completes ongoing  
28 training every twenty-four months thereafter. The training  
29 requirements may be approved as continuing education courses under  
30 chapter 48.17 RCW.

31        (2)(a) The one-time training required by this section shall consist  
32 of no fewer than eight hours of education and the ongoing training  
33 required by this section shall consist of no fewer than four hours.

34        (b) The one-time training required shall consist of topics related  
35 to long-term care insurance, long-term care services, and, if  
36 applicable, qualified state long-term care insurance partnership  
37 programs, including, but not limited to the following:

1 (i) State and federal regulations and requirements and the  
2 relationship between qualified state long-term care insurance  
3 partnership programs and other public and private coverage of long-term  
4 care services, including medicaid;

5 (ii) Available long-term services and providers;

6 (iii) Changes or improvements in long-term care services or  
7 providers;

8 (iv) Alternatives to the purchase of private long-term care  
9 insurance;

10 (v) The effect of inflation on benefits and the importance of  
11 inflation protection; chapters 48.84 and 48.85 RCW; and

12 (vi) Consumer suitability standards and guidelines.

13 (3) The training required by this section shall not include  
14 training that is issuer or company product-specific or that includes  
15 any sales or marketing information, materials, or training, other than  
16 those required by state or federal law.

17 (4) Issuers shall obtain verification that an insurance producer  
18 receives training required by subsection (1) of this section before  
19 that producer is permitted to sell, solicit, or otherwise negotiate the  
20 issuer's long-term care insurance products.

21 (5) Issuers shall maintain records subject to the state's record  
22 retention requirements and shall make evidence of that verification  
23 available to the commissioner upon request.

24 (6)(a) Issuers shall maintain records with respect to the training  
25 of its producers concerning the distribution of its long-term care  
26 partnership policies that will allow the commissioner to provide  
27 assurance to the state department of social and health services,  
28 medicaid division, that insurance producers engaged in the sale of  
29 long-term care insurance contracts have received the training required  
30 by this section and any rules adopted by the commissioner, and that  
31 producers have demonstrated an understanding of the partnership  
32 policies and their relationship to public and private coverage of long-  
33 term care, including medicaid, in this state.

34 (b) These records shall be maintained in accordance with the  
35 state's record retention requirements and shall be made available to  
36 the commissioner upon request.

37 (7) The satisfaction of these training requirements for any state  
38 shall be deemed to satisfy the training requirements of this state.

1           NEW SECTION.   **Sec. 15.** Issuers and their agents, if any, must  
2 determine whether issuing long-term care insurance coverage to a  
3 particular person is appropriate, except in the case of a life  
4 insurance policy that accelerates benefits for long-term care.

5           (1) An issuer must:

6           (a) Develop and use suitability standards to determine whether the  
7 purchase or replacement of long-term care coverage is appropriate for  
8 the needs of the applicant or insured;

9           (b) Train its agents in the use of the issuer's suitability  
10 standards; and

11           (c) Maintain a copy of its suitability standards and make the  
12 standards available for inspection, upon request.

13           (2) The following must be considered when determining whether the  
14 applicant meets the issuer's suitability standards:

15           (a) The ability of the applicant to pay for the proposed coverage  
16 and any other relevant financial information related to the purchase of  
17 or payment for coverage;

18           (b) The applicant's goals and needs with respect to long-term care  
19 and the advantages and disadvantages of long-term care coverage to meet  
20 those goals or needs; and

21           (c) The values, benefits, and costs of the applicant's existing  
22 health or long-term care coverage, if any, when compared to the values,  
23 benefits, and costs of the recommended purchase or replacement.

24           (3) The sale or transfer of any suitability information provided to  
25 the issuer or agent by the applicant to any other person or business  
26 entity is prohibited.

27           (4)(a) The commissioner shall adopt, by rule, forms of consumer-  
28 friendly personal worksheets that issuers and their agents must use for  
29 applications for long-term care coverage.

30           (b) The commissioner may require each issuer to file its current  
31 forms of suitability standards and personal worksheets with the  
32 commissioner.

33           NEW SECTION.   **Sec. 16.** A person engaged in the issuance or  
34 solicitation of long-term care coverage shall not engage in unfair  
35 methods of competition or unfair or deceptive acts or practices, as  
36 such methods, acts, or practices are defined in chapter 48.30 RCW, or  
37 as defined by the commissioner.

1        NEW SECTION.    **Sec. 17.** An issuer or an insurance producer who  
2 violates a law or rule relating to the regulation of long-term care  
3 insurance or its marketing shall be subject to a fine of up to three  
4 times the amount of the commission paid for each policy involved in the  
5 violation or up to ten thousand dollars, whichever is greater.

6        NEW SECTION.    **Sec. 18.** (1) The commissioner must adopt rules that  
7 include standards for full and fair disclosure setting forth the  
8 manner, content, and required disclosures for the sale of long-term  
9 care insurance policies, terms of renewability, initial and subsequent  
10 conditions of eligibility, nonduplication of coverage provisions,  
11 coverage of dependents, preexisting conditions, termination of  
12 insurance, continuation or conversion, probationary periods,  
13 limitations, exceptions, reductions, elimination periods, requirements  
14 for replacement, recurrent conditions, and definitions of terms. The  
15 commissioner must adopt rules establishing loss ratio standards for  
16 long-term care insurance policies. The commissioner must adopt rules  
17 to promote premium adequacy and to protect policyholders in the event  
18 of proposed substantial rate increases, and to establish minimum  
19 standards for producer education, marketing practices, producer  
20 compensation, producer testing, penalties, and reporting practices for  
21 long-term care insurance.

22        (2) The commissioner shall adopt rules establishing standards  
23 protecting patient privacy rights, rights to receive confidential  
24 health care services, and standards for an issuer's timely review of a  
25 claim denial upon request of a covered person.

26        (3) The commissioner may adopt reasonable rules to effectuate any  
27 provision of this chapter in accordance with the requirements of  
28 chapter 34.05 RCW.

29        **Sec. 19.** RCW 48.84.010 and 1986 c 170 s 1 are each amended to read  
30 as follows:

31        This chapter may be known and cited as the "long-term care  
32 insurance act" and is intended to govern the content and sale of long-  
33 term care insurance and long-term care benefit contracts issued before  
34 January 1, 2009, as defined in this chapter. This chapter shall be  
35 liberally construed to promote the public interest in protecting

1 purchasers of long-term care insurance from unfair or deceptive sales,  
2 marketing, and advertising practices. The provisions of this chapter  
3 shall apply in addition to other requirements of Title 48 RCW.

4 **Sec. 20.** RCW 48.43.005 and 2007 c 296 s 1 and 2007 c 259 s 32 are  
5 each reenacted and amended to read as follows:

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

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

12 (2) "Basic health plan" means the plan described under chapter  
13 70.47 RCW, as revised from time to time.

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

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

20 (5) "Catastrophic health plan" means:

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

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

35 (c) Any health benefit plan that provides benefits for hospital  
36 inpatient and outpatient services, professional and prescription drugs

1 provided in conjunction with such hospital inpatient and outpatient  
2 services, and excludes or substantially limits outpatient physician  
3 services and those services usually provided in an office setting.

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

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

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

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

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

26 (10) "Eligible employee" means an employee who works on a full-time  
27 basis with a normal work week of thirty or more hours. The term  
28 includes a self-employed individual, including a sole proprietor, a  
29 partner of a partnership, and may include an independent contractor, if  
30 the self-employed individual, sole proprietor, partner, or independent  
31 contractor is included as an employee under a health benefit plan of a  
32 small employer, but does not work less than thirty hours per week and  
33 derives at least seventy-five percent of his or her income from a trade  
34 or business through which he or she has attempted to earn taxable  
35 income and for which he or she has filed the appropriate internal  
36 revenue service form. Persons covered under a health benefit plan  
37 pursuant to the consolidated omnibus budget reconciliation act of 1986

1 shall not be considered eligible employees for purposes of minimum  
2 participation requirements of chapter 265, Laws of 1995.

3 (11) "Emergency medical condition" means the emergent and acute  
4 onset of a symptom or symptoms, including severe pain, that would lead  
5 a prudent layperson acting reasonably to believe that a health  
6 condition exists that requires immediate medical attention, if failure  
7 to provide medical attention would result in serious impairment to  
8 bodily functions or serious dysfunction of a bodily organ or part, or  
9 would place the person's health in serious jeopardy.

10 (12) "Emergency services" means otherwise covered health care  
11 services medically necessary to evaluate and treat an emergency medical  
12 condition, provided in a hospital emergency department.

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

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

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

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

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

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

16 (a) Long-term care insurance governed by chapter 48.84 ((RCW)) or  
17 48.-- RCW (sections 1 through 18 of this act);

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

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

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

24 (e) Disability income;

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

28 (g) Workers' compensation coverage;

29 (h) Accident only coverage;

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

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

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

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

1 education institution, after a written request for such classification  
2 by the carrier and subsequent written approval by the insurance  
3 commissioner.

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

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

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

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

22 (24) "Small employer" or "small group" means any person, firm,  
23 corporation, partnership, association, political subdivision, sole  
24 proprietor, or self-employed individual that is actively engaged in  
25 business that, on at least fifty percent of its working days during the  
26 preceding calendar quarter, employed at least two but no more than  
27 fifty eligible employees, with a normal work week of thirty or more  
28 hours, the majority of whom were employed within this state, and is not  
29 formed primarily for purposes of buying health insurance and in which  
30 a bona fide employer-employee relationship exists. In determining the  
31 number of eligible employees, companies that are affiliated companies,  
32 or that are eligible to file a combined tax return for purposes of  
33 taxation by this state, shall be considered an employer. Subsequent to  
34 the issuance of a health plan to a small employer and for the purpose  
35 of determining eligibility, the size of a small employer shall be  
36 determined annually. Except as otherwise specifically provided, a  
37 small employer shall continue to be considered a small employer until  
38 the plan anniversary following the date the small employer no longer

1 meets the requirements of this definition. A self-employed individual  
2 or sole proprietor must derive at least seventy-five percent of his or  
3 her income from a trade or business through which the individual or  
4 sole proprietor has attempted to earn taxable income and for which he  
5 or she has filed the appropriate internal revenue service form 1040,  
6 schedule C or F, for the previous taxable year except for a self-  
7 employed individual or sole proprietor in an agricultural trade or  
8 business, who must derive at least fifty-one percent of his or her  
9 income from the trade or business through which the individual or sole  
10 proprietor has attempted to earn taxable income and for which he or she  
11 has filed the appropriate internal revenue service form 1040, for the  
12 previous taxable year. A self-employed individual or sole proprietor  
13 who is covered as a group of one on the day prior to June 10, 2004,  
14 shall also be considered a "small employer" to the extent that  
15 individual or group of one is entitled to have his or her coverage  
16 renewed as provided in RCW 48.43.035(6).

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

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

29 **Sec. 21.** RCW 48.85.010 and 1995 1st sp.s. c 18 s 76 are each  
30 amended to read as follows:

31 The department of social and health services shall, in conjunction  
32 with the office of the insurance commissioner, coordinate a long-term  
33 care insurance program entitled the Washington long-term care  
34 partnership, whereby private insurance and medicaid funds shall be used  
35 to finance long-term care. For individuals purchasing a long-term care  
36 insurance policy or contract governed by chapter 48.84 ((RCW)) or 48.--  
37 RCW (sections 1 through 18 of this act) and meeting the criteria

1 prescribed in this chapter, and any other terms as specified by the  
2 office of the insurance commissioner and the department of social and  
3 health services, this program shall allow for the exclusion of some or  
4 all of the individual's assets in determination of medicaid eligibility  
5 as approved by the federal health care financing administration.

6 NEW SECTION. **Sec. 22.** Sections 1 through 18 of this act  
7 constitute a new chapter in Title 48 RCW.

8 NEW SECTION. **Sec. 23.** If any provision of this act or its  
9 application to any person or circumstance is held invalid, the  
10 remainder of the act or the application of the provision to other  
11 persons or circumstances is not affected.

12 NEW SECTION. **Sec. 24.** This act takes effect January 1, 2009.

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