

CERTIFICATION OF ENROLLMENT

**SENATE BILL 6405**

Chapter 65, Laws of 2016

64th Legislature  
2016 Regular Session

CIVILIAN HEALTH AND MEDICAL PROGRAM--TREATED AS GROUP DISABILITY  
INSURANCE

EFFECTIVE DATE: 6/9/2016

Passed by the Senate February 5, 2016  
Yeas 49 Nays 0

BRAD OWEN

**President of the Senate**

Passed by the House March 4, 2016  
Yeas 97 Nays 0

FRANK CHOPP

**Speaker of the House of Representatives**

Approved March 29, 2016 4:20 PM

JAY INSLEE

**Governor of the State of Washington**

CERTIFICATE

I, Hunter G. Goodman, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SENATE BILL 6405** as passed by Senate and the House of Representatives on the dates hereon set forth.

HUNTER G. GOODMAN

**Secretary**

FILED

March 30, 2016

**Secretary of State  
State of Washington**

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SENATE BILL 6405

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Passed Legislature - 2016 Regular Session

State of Washington

64th Legislature

2016 Regular Session

By Senators Benton, Roach, McCoy, O'Ban, Angel, and Conway

Read first time 01/19/16. Referred to Committee on Financial Institutions & Insurance.

1 AN ACT Relating to the civilian health and medical program for  
2 the veterans affairs administration; amending RCW 48.21.010; and  
3 reenacting and amending RCW 48.43.005.

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

5 **Sec. 1.** RCW 48.21.010 and 2011 c 81 s 1 are each amended to read  
6 as follows:

7 (1) Group disability insurance is that form of disability  
8 insurance, including stop loss insurance as defined in RCW 48.11.030,  
9 provided by a master policy issued to an employer, to a trustee  
10 appointed by an employer or employers, or to an association of  
11 employers formed for purposes other than obtaining such insurance,  
12 covering, with or without their dependents, the employees, or  
13 specified categories of the employees, of such employers or their  
14 subsidiaries or affiliates, or issued to a labor union, or to an  
15 association of employees formed for purposes other than obtaining  
16 such insurance, covering, with or without their dependents, the  
17 members, or specified categories of the members, of the labor union  
18 or association, or issued pursuant to RCW 48.21.030. Group disability  
19 insurance includes the following groups that qualify for group life  
20 insurance:

1 RCW 48.24.020, 48.24.035, 48.24.040, 48.24.045, 48.24.050,  
2 48.24.060, 48.24.070, 48.24.080, 48.24.090, and 48.24.095. A group  
3 under RCW 48.24.027 does not qualify as a group for the purposes of  
4 this chapter.

5 (2) Group disability insurance for lines of coverage identified  
6 in RCW 48.43.005(~~((19))~~) (26) (e), (h), (~~(and)~~) (k), and (m) offered  
7 to a resident of this state under a group disability insurance policy  
8 may be issued to a group other than the groups described in  
9 subsection (1) of this section subject to the requirements in this  
10 subsection.

11 (a) A group disability insurance policy offered under this  
12 subsection may not be delivered in this state unless the commissioner  
13 finds that:

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

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

18 (iii) The benefits are reasonable in relation to the premium  
19 charged.

20 (b) A group disability insurance coverage may not be offered  
21 under this subsection in this state by an insurer under a policy  
22 issued in another state unless the commissioner or the insurance  
23 commissioner of another state having requirements substantially  
24 similar to those contained in this subsection has made a  
25 determination that the requirements have been met.

26 **Sec. 2.** RCW 48.43.005 and 2012 c 211 s 17 and 2012 c 87 s 1 are  
27 each reenacted and 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  
32 actuarially demonstrated differences in utilization or cost  
33 attributable to geographic region, age, family size, and use of  
34 wellness activities.

35 (2) "Adverse benefit determination" means a denial, reduction, or  
36 termination of, or a failure to provide or make payment, in whole or  
37 in part, for a benefit, including a denial, reduction, termination,  
38 or failure to provide or make payment that is based on a  
39 determination of an enrollee's or applicant's eligibility to

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

8 (3) "Applicant" means a person who applies for enrollment in an  
9 individual health plan as the subscriber or an enrollee, or the  
10 dependent or spouse of a subscriber or enrollee.

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

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

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

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

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

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

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

38 (b) In July 2008, and in each July thereafter, the insurance  
39 commissioner shall adjust the minimum deductible and out-of-pocket  
40 expense required for a plan to qualify as a catastrophic plan to

1 reflect the percentage change in the consumer price index for medical  
2 care for a preceding twelve months, as determined by the United  
3 States department of labor. For a plan year beginning in 2014, the  
4 out-of-pocket limits must be adjusted as specified in section  
5 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount  
6 shall apply on the following January 1st.

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

9 (i) A health benefit plan that meets the definition of  
10 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of  
11 2010, as amended; or

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

17 (9) "Certification" means a determination by a review  
18 organization that an admission, extension of stay, or other health  
19 care service or procedure has been reviewed and, based on the  
20 information provided, meets the clinical requirements for medical  
21 necessity, appropriateness, level of care, or effectiveness under the  
22 auspices of the applicable health benefit plan.

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

25 (11) "Covered person" or "enrollee" means a person covered by a  
26 health plan including an enrollee, subscriber, policyholder,  
27 beneficiary of a group plan, or individual covered by any other  
28 health plan.

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

32 (13) "Emergency medical condition" means a medical condition  
33 manifesting itself by acute symptoms of sufficient severity,  
34 including severe pain, such that a prudent layperson, who possesses  
35 an average knowledge of health and medicine, could reasonably expect  
36 the absence of immediate medical attention to result in a condition

37 (a) placing the health of the individual, or with respect to a  
38 pregnant woman, the health of the woman or her unborn child, in  
39 serious jeopardy, (b) serious impairment to bodily functions, or (c)  
40 serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

37 (21) "Grievance" means a written complaint submitted by or on  
38 behalf of a covered person regarding service delivery issues other  
39 than denial of payment for medical services or nonprovision of  
40 medical services, including dissatisfaction with medical care,

1 waiting time for medical services, provider or staff attitude or  
2 demeanor, or dissatisfaction with service provided by the health  
3 carrier.

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

17 (23) "Health care provider" or "provider" means:

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

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

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

26 (25) "Health carrier" or "carrier" means a disability insurer  
27 regulated under chapter 48.20 or 48.21 RCW, a health care service  
28 contractor as defined in RCW 48.44.010, or a health maintenance  
29 organization as defined in RCW 48.46.020, and includes "issuers" as  
30 that term is used in the patient protection and affordable care act  
31 (P.L. 111-148).

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

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

38 (b) Medicare supplemental health insurance governed by chapter  
39 48.66 RCW;

1 (c) Coverage supplemental to the coverage provided under chapter  
2 55, Title 10, United States Code;

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

5 (e) Disability income;

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

9 (g) Workers' compensation coverage;

10 (h) Accident only coverage;

11 (i) Specified disease or illness-triggered fixed payment  
12 insurance, hospital confinement fixed payment insurance, or other  
13 fixed payment insurance offered as an independent, noncoordinated  
14 benefit;

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

16 (k) Dental only and vision only coverage; (~~and~~)

17 (l) Plans deemed by the insurance commissioner to have a short-  
18 term limited purpose or duration, or to be a student-only plan that  
19 is guaranteed renewable while the covered person is enrolled as a  
20 regular full-time undergraduate or graduate student at an accredited  
21 higher education institution, after a written request for such  
22 classification by the carrier and subsequent written approval by the  
23 insurance commissioner; and

24 (m) Civilian health and medical program for the veterans affairs  
25 administration (CHAMPVA).

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

29 (28) "Material modification" means a change in the actuarial  
30 value of the health plan as modified of more than five percent but  
31 less than fifteen percent.

32 (29) "Open enrollment" means a period of time as defined in rule  
33 to be held at the same time each year, during which applicants may  
34 enroll in a carrier's individual health benefit plan without being  
35 subject to health screening or otherwise required to provide evidence  
36 of insurability as a condition for enrollment.

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



1 (31) "Premium" means all sums charged, received, or deposited by  
2 a health carrier as consideration for a health plan or the  
3 continuance of a health plan. Any assessment or any "membership,"  
4 "policy," "contract," "service," or similar fee or charge made by a  
5 health carrier in consideration for a health plan is deemed part of  
6 the premium. "Premium" shall not include amounts paid as enrollee  
7 point-of-service cost-sharing.

8 (32) "Review organization" means a disability insurer regulated  
9 under chapter 48.20 or 48.21 RCW, health care service contractor as  
10 defined in RCW 48.44.010, or health maintenance organization as  
11 defined in RCW 48.46.020, and entities affiliated with, under  
12 contract with, or acting on behalf of a health carrier to perform a  
13 utilization review.

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

1 percent of his or her income from the trade or business through which  
2 the individual or sole proprietor has attempted to earn taxable  
3 income and for which he or she has filed the appropriate internal  
4 revenue service form 1040, for the previous taxable year.

5 (34) "Special enrollment" means a defined period of time of not  
6 less than thirty-one days, triggered by a specific qualifying event  
7 experienced by the applicant, during which applicants may enroll in  
8 the carrier's individual health benefit plan without being subject to  
9 health screening or otherwise required to provide evidence of  
10 insurability as a condition for enrollment.

11 (35) "Standard health questionnaire" means the standard health  
12 questionnaire designated under chapter 48.41 RCW.

13 (36) "Utilization review" means the prospective, concurrent, or  
14 retrospective assessment of the necessity and appropriateness of the  
15 allocation of health care resources and services of a provider or  
16 facility, given or proposed to be given to an enrollee or group of  
17 enrollees.

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

Passed by the Senate February 5, 2016.

Passed by the House March 4, 2016.

Approved by the Governor March 29, 2016.

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