CERTIFICATION OF ENROLLMENT

HOUSE BILL 1083

Chapter 248, Laws of 2003

58th Legislature
2003 Regular Session

INSURANCE

EFFECTIVE DATE: 7/27/03

Passed by the House February 12, 2003
Yeas 97 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 16, 2003
Yeas 48 Nays 0

BRAD OWEN

President of the Senate

Approved May 12, 2003.

GARY F. LOCKE

Governor of the State of Washington

CERTIFICATE

I, Cynthia Zehnder, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 1083** as passed by the House of Representatives and the Senate on the dates hereon set forth.

CYNTHIA ZEHNDER

Chief Clerk

FILED

May 12, 2003 - 4:27 p.m.

Secretary of State
State of Washington

HOUSE BILL 1083

Passed Legislature - 2003 Regular Session

State of Washington 58th Legislature 2003 Regular Session

By Representatives Simpson, Benson and Schual-Berke; by request of Insurance Commissioner

Read first time 01/15/2003. Referred to Committee on Financial Institutions & Insurance.

AN ACT Relating to making clarifying, nonsubstantive amendments to and correcting outdated references in the insurance code; and amending RCW 48.01.050, 48.01.235, 48.14.029, 48.18.103, 48.18.291, 48.18A.050, 48.19.043, 48.20.025, 48.21.180, 48.22.110, 48.31.111, 48.31.184, 48.31.185, 48.43.115, 48.44.024, 48.46.068, 48.46.170, 48.46.225, 48.46.350, 48.62.111, 48.90.010, 48.90.020, 48.90.030, 48.90.140, and 48.99.040.

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

Sec. 1. RCW 48.01.050 and 1990 c 130 s 1 are each amended to read as follows:

"Insurer" as used in this code includes every person engaged in the business of making contracts of insurance, other than a fraternal benefit society. A reciprocal or interinsurance exchange is an "insurer" as used in this code. Two or more hospitals((~~, as defined in RCW 70.39.020(3), which~~)) that join and organize as a mutual corporation pursuant to chapter 24.06 RCW for the purpose of insuring or self-insuring against liability claims, including medical liability, through a contributing trust fund ((~~shall not be deemed~~)) are not an "insurer" under this code. Two or more local governmental entities,

((~~as defined in RCW 48.62.020, which pursuant to RCW 48.62.040, 48.62.035, or any other~~)) under any provision of law, that join together and organize to form an organization for the purpose of jointly self-insuring or self-funding ((~~shall not be deemed~~)) are not an "insurer" under this code. Two or more persons engaged in the business of commercial fishing who enter into an arrangement with other such persons for the pooling of funds to pay claims or losses arising out of loss or damage to a vessel or machinery used in the business of commercial fishing and owned by a member of the pool ((~~shall not be deemed~~)) are not an "insurer" under this code.

Sec. 2. RCW 48.01.235 and 1995 c 34 s 3 are each amended to read as follows:

(1) An issuer and an employee welfare benefit plan, whether insured or self funded, as defined in the employee retirement income security act of 1974, 29 U.S.C. Sec. 1101 et seq. may not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the parent or in the issuer's, or insured or self funded employee welfare benefit plan's service area.

(2) Where a child has health coverage through an issuer, or an insured or self funded employee welfare benefit plan of a noncustodial parent((~~[,]~~)), the issuer, or insured or self funded employee welfare benefit plan, shall:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the provider or the custodial parent to submit claims for covered services without the approval of the noncustodial parent. If the provider submits the claim, the provider will obtain the custodial parent's assignment of insurance benefits or otherwise secure the custodial parent's approval.

For purposes of this subsection the department of social and health services as the state medicaid agency under RCW 74.09.500 may reassign medical insurance rights to the provider for custodial parents whose children are eligible for services under RCW 74.09.500; and

(c) Make payments on claims submitted in accordance with (b) of this subsection directly to the custodial parent, to the provider, or to the department of social and health services as the state medicaid agency under RCW 74.09.500.

(3) Where a child does not reside in the issuer's service area, an issuer shall cover no less than urgent and emergent care. Where the issuer offers broader coverage, whether by policy or reciprocal agreement, the issuer shall provide such coverage to any child otherwise covered that does not reside in the issuer's service area.

(4) Where a parent is required by a court order to provide health coverage for a child, and the parent is eligible for family health coverage, the issuer, or insured or self funded employee welfare benefit plan, shall:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) Enroll the child under family coverage upon application of the child's other parent, department of social and health services as the state medicaid agency under RCW 74.09.500, or child support enforcement program ((~~as defined under RCW 26.18.170~~)), if the parent is enrolled but fails to make application to obtain coverage for such child; and

(c) Not disenroll, or eliminate coverage of, such child who is otherwise eligible for the coverage unless the issuer or insured or self funded employee welfare benefit plan is provided satisfactory written evidence that:

(i) The court order is no longer in effect; or

(ii) The child is or will be enrolled in comparable health coverage through another issuer, or insured or self funded employee welfare benefit plan, which will take effect not later than the effective date of disenrollment.

(5) An issuer, or insured or self funded employee welfare benefit plan, that has been assigned the rights of an individual eligible for medical assistance under medicaid and coverage for health benefits from the issuer, or insured or self funded employee welfare benefit plan, may not impose requirements on the department of social and health services that are different from requirements applicable to an agent or assignee of any other individual so covered.

Sec. 3. RCW 48.14.029 and 1998 c 313 s 3 are each amended to read as follows:

(1) Subject to the limits in this section, an eligible person is allowed a credit against the tax due under RCW 48.14.020. The credit is based on qualified employment positions in eligible areas. The credit is available to persons who are engaged in international insurance services as defined in this section. In order to receive the credit, the international insurance services activities must take place at a business within the eligible area.

(2)(a) The credit shall equal three thousand dollars for each qualified employment position created after July 1, 1998, in an eligible area. A credit is earned for the calendar year the person is hired to fill the position, plus the four subsequent consecutive years, if the position is maintained for those four years.

(b) Credit may not be taken for hiring of persons into positions that exist on July 1, 1998. Credit is authorized for new employees hired for new positions created after July 1, 1998. New positions filled by existing employees are eligible for the credit under this section only if the position vacated by the existing employee is filled by a new hire.

(c) When a position is newly created, if it is filled before July 1st, this position is eligible for the full yearly credit. If it is filled after June 30th, this position is eligible for half of the credit.

(d) Credit may be accrued and carried over until it is used. No refunds may be granted for credits under this section.

(3) For the purposes of this section:

(a) "Eligible area" means: (i) A community empowerment zone under RCW ((~~43.63A.700~~)) 43.31C.020; or (ii) a contiguous group of census tracts that meets the unemployment and poverty criteria of RCW ((~~43.63A.710~~)) 43.31C.030 and is designated under subsection (4) of this section;

(b) "Eligible person" means a person, as defined in RCW 82.04.030, who in an eligible area at a specific location is engaged in the business of providing international insurance services;

(c) "International insurance services" means a business that provides insurance services related directly to the delivery of the

service outside the United States or on behalf of persons residing outside the United States; and

(d) "Qualified employment position" means a permanent full-time position to provide international insurance services. If an employee is either voluntarily or involuntarily separated from employment, the employment position is considered filled on a full-time basis if the employer is either training or actively recruiting a replacement employee.

(4) By ordinance, the legislative authority of a city with population greater than eighty thousand, located in a county containing no community empowerment zones as designated under RCW ((~~43.63A.700~~)) 43.31C.020, may designate a contiguous group of census tracts within the city as an eligible area under this section. Each of the census tracts must meet the unemployment and poverty criteria of RCW ((~~43.63A.710~~)) 43.31C.030. Upon making the designation, the city shall transmit to the department of revenue a certification letter and a map, each explicitly describing the boundaries of the census tract. This designation must be made by December 31, 1998.

(5) No application is necessary for the tax credit. The person must keep records necessary for the department to verify eligibility under this section. This information includes:

(a) Employment records for the previous six years;

(b) Information relating to description of international insurance services activity engaged in at the eligible location by the person; and

(c) Information relating to customers of international insurance services activity engaged in at that location by the person.

(6) If at any time the department finds that a person is not eligible for tax credit under this section, the amount of taxes for which a credit has been used shall be immediately due. The department shall assess interest, but not penalties, on the credited taxes for which the person is not eligible. The interest shall be assessed at the rate provided for delinquent excise taxes under chapter 82.32 RCW, shall be assessed retroactively to the date the tax credit was taken, and shall accrue until the taxes for which a credit has been used are repaid.

(7) The employment security department shall provide to the

department of revenue such information needed by the department of revenue to verify eligibility under this section.

Sec. 4. RCW 48.18.103 and 1997 c 428 s 1 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for forms.

(2) Commercial property casualty policies may be issued prior to filing the forms. All commercial property casualty forms shall be filed with the commissioner within thirty days after an insurer issues any policy using them.

(3) If, within thirty days after a commercial property casualty form has been filed, the commissioner finds that the form does not meet the requirements of this chapter, the commissioner shall disapprove the form and give notice to the insurer or rating organization that made the filing, specifying how the form fails to meet the requirements and stating when, within a reasonable period thereafter, the form shall be deemed no longer effective. The commissioner may extend the time for review another fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(4) Upon a final determination of a disapproval of a policy form under subsection (3) of this section, the insurer shall amend any previously issued disapproved form by endorsement to comply with the commissioner's disapproval.

(5) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, ((~~or~~)) occupation<u>, nonprofit organization, or public entity</u> for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070.

(6) Except as provided in subsection (4) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(7) In the event a hearing is held on the actions of the commissioner under subsection (3) of this section, the burden of proof shall be on the commissioner.

Sec. 5. RCW 48.18.291 and 1985 c 264 s 18 are each amended to read as follows:

(1) ((~~No~~)) A contract of insurance predicated wholly or in part upon the use of a private passenger automobile ((~~shall~~)) may not be terminated by cancellation by the insurer until at least twenty days after mailing written notice of cancellation to the named insured at the latest address filed with the insurer by or on behalf of the named insured, accompanied by the reason therefor((~~: PROVIDED, That where~~)). If cancellation is for nonpayment of premium, or is within the first thirty days after the contract has been in effect, at least ten days notice of cancellation, accompanied by the reason therefor, shall be given((~~: PROVIDED HOWEVER, That~~)). In case of a contract evidenced by a written binder which has been delivered to the insured, if ((~~such~~)) the binder contains a clearly stated expiration date, no additional notice of cancellation or nonrenewal ((~~shall be~~)) is required.

(2)(a) ((~~No~~)) A notice of cancellation by the insurer as to a contract of insurance to which subsection (1) of this section applies ((~~shall be~~)) is not valid if sent more than sixty days after the contract has been in effect unless:

(i) The named insured fails to discharge when due any of his or her obligations in connection with the payment of premium for the policy or any installment thereof, whether payable directly to the insurer or to its agent or indirectly under any premium finance plan or extension of credit((~~.~~)); or

(ii) The driver's license of the named insured, or of any other operator who customarily operates an automobile insured under the policy, has been ((~~under suspension or revocation~~)) suspended, revoked, or cancelled during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty days immediately preceding the effective date of the renewal policy.

(b) Modification by the insurer of automobile physical damage coverage by the inclusion of a deductible not exceeding one hundred dollars ((~~shall not be deemed~~)) is not a cancellation of the coverage or of the policy.

(3) The substance of subsections (1) and (2)(a) of this section must be set forth in each contract of insurance subject to the provisions of subsection (1) ((~~above~~)) of this section, and may be in the form of an attached endorsement.

(4) ((~~No~~)) A notice of cancellation of a policy ((~~which can~~)) that may be canceled only pursuant to subsection (2) ((~~shall be~~)) of this section is not effective unless the reason therefor accompanies or is included in the notice of cancellation.

Sec. 6. RCW 48.18A.050 and 1983 c 3 s 150 are each amended to read as follows:

The provisions of RCW 48.23.020, 48.23.030, 48.23.080 through 48.23.120, 48.23.140, 48.23.150, 48.23.200 through 48.23.240, 48.23.310, ((~~48.23.350,~~)) and 48.23.360, and the provisions of chapters 48.24 and 48.76 RCW ((~~shall be~~)) are inapplicable to variable contracts((~~; nor shall~~)). Any provision in the code requiring contracts to be participating ((~~be deemed~~)) is not applicable to variable contracts. Except as otherwise provided in this chapter, all pertinent provisions of the insurance code ((~~shall~~)) apply to separate accounts and contracts relating thereto. Any individual variable life insurance or individual variable annuity contract delivered or issued for delivery in this state ((~~shall~~)) must contain grace, reinstatement, and nonforfeiture provisions appropriate to ((~~such~~)) those contracts, and any ((~~such~~)) variable life insurance contract ((~~shall~~)) must provide that the investment experience of the separate account ((~~shall in no event~~)) may not operate to reduce the death benefit below an amount equal to the face amount of the contract at the time the contract was issued. Any individual variable life insurance contract may contain a provision for deduction from the death proceeds of amounts of due and unpaid premiums or of indebtedness which are appropriate to ((~~such~~)) that contract((~~s~~)). The reserve liability for variable annuities ((~~shall~~)) must be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

Sec. 7. RCW 48.19.043 and 1997 c 428 s 2 are each amended to read as follows:

(1) It is the intent of the legislature to assist the purchasers of commercial property casualty insurance by allowing policies to be issued more expeditiously and provide a more competitive market for rates.

(2) Notwithstanding the provisions of RCW 48.19.040(1), commercial property casualty policies may be issued prior to filing the rates. All commercial property casualty rates shall be filed with the commissioner within thirty days after an insurer issues any policy using them.

(3) If, within thirty days after a commercial property casualty rate has been filed, the commissioner finds that the rate does not meet the requirements of this chapter, the commissioner shall disapprove the filing and give notice to the insurer or rating organization that made the filing, specifying how the filing fails to meet the requirements and stating when, within a reasonable period thereafter, the filing shall be deemed no longer effective. The commissioner may extend the time for review another fifteen days by giving notice to the insurer prior to the expiration of the original thirty-day period.

(4) Upon a final determination of a disapproval of a rate filing under subsection (3) of this section, the insurer shall issue an endorsement changing the rate to comply with the commissioner's disapproval from the date the rate is no longer effective.

(5) For purposes of this section, "commercial property casualty" means insurance pertaining to a business, profession, ((~~or~~)) occupation, nonprofit organization, or public entity for the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, or 48.11.070.

(6) Except as provided in subsection (4) of this section, the disapproval shall not affect any contract made or issued prior to the expiration of the period set forth in the notice of disapproval.

(7) In the event a hearing is held on the actions of the commissioner under subsection (3) of this section, the burden of proof ((~~shall be~~)) is on the commissioner.

Sec. 8. RCW 48.20.025 and 2001 c 196 s 1 are each amended to read as follows:

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

(a) "Claims" means the cost to the insurer of health care services, as defined in RCW 48.43.005, provided to a policyholder or paid to or on behalf of the policyholder in accordance with the terms of a health

benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for a policyholder.

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

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

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

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

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

(2) An insurer shall file, for informational purposes only, a notice of its schedule of rates for its individual health benefit plans with the commissioner prior to use.

(3) An insurer shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request only the following supporting documentation:

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

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

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

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

(4) The commissioner may not disapprove or otherwise impede the implementation of the filed rates.

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

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

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

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

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

(a) The insurer shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (7) of this section.

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

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

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

(7) The loss ratio applicable to this section shall be seventy-four percent minus the premium tax rate applicable to the insurer's individual health benefit plans under RCW ((~~48.14.0201~~)) 48.14.020.

Sec. 9. RCW 48.21.180 and 1990 1st ex.s. c 3 s 7 are each amended to read as follows:

Each group disability insurance contract which is delivered or issued for delivery or renewed, on or after January 1, 1988, and which insures for hospital or medical care ((~~shall~~)) must contain provisions providing benefits for the treatment of chemical dependency rendered to the insured by a provider which is an "approved treatment ((~~facility or~~)) program" under RCW 70.96A.020(3).

Sec. 10. RCW 48.22.110 and 1994 c 186 s 1 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this section and RCW 48.22.115 through 48.22.135.

(1) "Borrower" means a person who receives a loan or enters into a retail installment contract under chapter 63.14 RCW to purchase a motor vehicle or vessel in which the secured party holds an interest.

(2) "Motor vehicle" means a motor vehicle in this state subject to registration under chapter 46.16 RCW, except motor vehicles governed by RCW 46.16.020 or registered with the Washington utilities and transportation commission as common or contract carriers.

(3) "Secured party" means a person, corporation, association, partnership, or venture that possesses a bona fide security interest in a motor vehicle or vessel.

(4) "Vendor single-interest" or "collateral protection coverage" means insurance coverage insuring primarily or solely the interest of a secured party but which may include the interest of the borrower in a motor vehicle or vessel serving as collateral and obtained by the secured party or its agent after the borrower has failed to obtain or maintain insurance coverage required by the financing agreement for the

motor vehicle or vessel. Vendor single-interest or collateral protection coverage does not include insurance coverage purchased by a secured party for which the borrower is not charged.

(5) "Vessel" means a vessel as defined in RCW 88.02.010 and includes personal watercraft as defined in RCW ((~~88.12.010~~)) 79A.60.010.

Sec. 11. RCW 48.31.111 and 1993 c 462 s 59 are each amended to read as follows:

(1) ((~~Except as provided in RCW 48.32A.060, no~~)) A delinquency proceeding may not be commenced under this chapter by anyone other than the commissioner of this state, and no court has jurisdiction to entertain a proceeding commenced by another person.

(2) No court of this state has jurisdiction to entertain a complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of an insurer, or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to the proceedings, other than in accordance with this chapter.

(3) In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served under the rules of civil procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(a) If the person served is an agent, broker, or other person who has written policies of insurance for or has acted in any manner on behalf of an insurer against which a delinquency proceeding has been instituted, in an action resulting from or incident to such a relationship with the insurer; ((~~or~~))

(b) If the person served is a reinsurer who has entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in an action on or incident to the reinsurance contract; ((~~or~~))

(c) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of

comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in an action resulting from or incident to such a relationship with the insurer; ((~~or~~))

(d) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in an action concerning the assets; or

(e) If the person served is obligated to the insurer in any way, in an action on or incident to the obligation.

(4) If the court on motion of a party finds that an action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

Sec. 12. RCW 48.31.184 and 1993 c 462 s 74 are each amended to read as follows:

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state assets within his or her control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, then the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under RCW 48.31.280((~~(7)~~)) (8).

Sec. 13. RCW 48.31.185 and 1975-'76 2nd ex.s. c 109 s 10 are each amended to read as follows:

(1) Within one hundred twenty days of a final determination of insolvency of an insurer and order of liquidation by a court of competent jurisdiction of this state, the receiver shall make application to the court for approval of a proposal to disperse assets out of ((~~such~~)) that insurer's marshalled assets from time to time as ((~~such~~)) assets become available to the Washington insurance guaranty association and the Washington life and disability insurance guaranty association and to any entity or person performing a similar function in another state. ((~~(~~)) For purposes of this section, "associations" means the Washington insurance guaranty association and the Washington life and disability insurance guaranty association and any entity or

person performing a similar function in other states ((~~shall in this section be referred to collectively as the "associations".~~)).

(2) Such a proposal ((~~shall~~)) must at least include provisions for:

(a) Reserving amounts for the payment of claims falling within the priorities established in RCW 48.31.280 ((~~(2)(a), (b), and (c) as now or hereafter amended~~));

(b) Disbursement of the assets marshalled to date and subsequent disbursements of assets as they become available;

(c) Equitable allocation of disbursements to each of the associations entitled thereto;

(d) The securing by the receiver from each of the associations entitled to disbursements pursuant to this section an agreement to return to the receiver ((~~such~~)) assets previously disbursed ((~~as may be~~)) that are required to pay claims of secured creditors and claims falling within the priorities established in RCW 48.31.280 ((~~as now or hereafter amended in accordance with such priorities~~)). ((~~No~~)) A bond ((~~shall be~~)) is not required of any ((~~such~~)) association; and

(e) A full report ((~~to be made~~)) by the association to the receiver accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on ((~~such~~)) those assets, and any other matters as the court may direct.

(3) The receiver's proposal ((~~shall~~)) must provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the receiver, and ((~~shall~~)) must further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of ((~~such~~)) the claim payments made or to be made by the associations then disbursements ((~~shall~~)) must be in the amount of available assets.

(4) The receiver's proposal shall, with respect to an insolvent insurer writing life insurance, disability insurance, or annuities, provide for disbursements of assets to the Washington life and disability insurance guaranty association or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the provisions of the Washington life and disability insurance guaranty association act.

(5) Notice of ((~~such~~)) an application ((~~shall~~)) must be given to the associations in and to the commissioners of insurance of each of

the states. ((~~Any such~~)) Notice ((~~shall be deemed to have been given~~)) is effected when deposited in the United States certified mails, first class postage prepaid, at least thirty days prior to submission of ((~~such~~)) the application to the court.

Sec. 14. RCW 48.43.115 and 1996 c 281 s 1 are each amended to read as follows:

(1) The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services to maternity patients and their newly born children. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding services provided and the length of time individual patients may need to remain in a health care facility after giving birth. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual postpartum needs.

(2) Unless otherwise specifically provided, the following definitions apply throughout this section:

(a) "Attending provider" means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW, a certified nurse midwife licensed under chapter 18.79 RCW, a midwife licensed under chapter 18.50 RCW, a physician's assistant licensed under chapter 18.57A or 18.71A RCW, or an advanced registered nurse practitioner licensed under chapter 18.79 RCW.

(b) "Health carrier" or "carrier" means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.

(3)(a) Every health carrier that provides coverage for maternity services must permit the attending provider, in consultation with the

mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Covered eligible services may not be denied for inpatient, postdelivery care to a mother and her newly born child after a vaginal delivery or a cesarean section delivery for such care as ordered by the attending provider in consultation with the mother.

(c) At the time of discharge, determination of the type and location of follow-up care((~~, including in-person care,~~)) must be made by the attending provider in consultation with the mother rather than by contract or agreement between the hospital and the insurer. These decisions must be based on accepted medical practice.

(d) Covered eligible services may not be denied for follow-up care, including in-person care, as ordered by the attending provider in consultation with the mother. Coverage for providers of follow-up services must include, but need not be limited to, attending providers as defined in this section, home health agencies licensed under chapter 70.127 RCW, and registered nurses licensed under chapter 18.79 RCW.

(e) ((~~Nothing in~~)) This section ((~~shall be construed to~~)) does not require attending providers to authorize care they believe to be medically unnecessary.

(f) Coverage for the newly born child must be no less than the coverage of the child's mother for no less than three weeks, even if there are separate hospital admissions.

(4) ((~~No~~)) A carrier that provides coverage for maternity services may not deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with ((~~the provisions of~~)) this section. ((~~Nothing in~~)) This section ((~~shall be construed to~~)) does not prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(5) Every carrier that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be

transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following June 6, 1996.

(6) This section ((~~is not intended to~~)) does not establish a standard of medical care.

(7) This section ((~~shall apply~~)) applies to coverage for maternity services under a contract issued or renewed by a health carrier after June 6, 1996, and ((~~shall apply~~)) applies to plans operating under the health care authority under chapter 41.05 RCW beginning January 1, 1998.

Sec. 15. RCW 48.44.024 and 1995 c 265 s 23 are each amended to read as follows:

(1) ((~~No~~)) A health care service contractor ((~~shall~~)) may not offer any health benefit plan to any small employer without complying with ((~~the provisions of~~)) RCW 48.44.023((~~(5)~~)) (3).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care ((~~shall not be considered~~)) are not small employers and ((~~such plans shall not be subject to the provisions of RCW 48.44.023(5)~~)) the plans are not subject to RCW 48.44.023(3).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 16. RCW 48.46.068 and 1995 c 265 s 24 are each amended to read as follows:

(1) ((~~No~~)) A health maintenance organization ((~~shall~~)) may not offer any health benefit plan to any small employer without complying with ((~~the provisions of~~)) RCW 48.46.066((~~(5)~~)) (3).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care ((~~shall not be considered~~)) are not small employers and ((~~such plans shall not be subject to the provisions of RCW 48.46.066(5)~~)) are not subject to RCW 48.46.066(3).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 17. RCW 48.46.170 and 1996 c 178 s 13 are each amended to read as follows:

(1) Solicitation of enrolled participants by a health maintenance organization granted a certificate of registration, or its agents or representatives, ((~~shall not be construed to~~)) does not violate any provision of law relating to solicitation or advertising by health professionals.

(2) Any health maintenance organization authorized under this chapter ((~~shall not be deemed to be~~)) is not violating any law prohibiting the practice by unlicensed persons of podiatric medicine and surgery, chiropractic, dental hygiene, opticianry, dentistry, optometry, osteopathic medicine and surgery, pharmacy, medicine and surgery, physical therapy, nursing, or psychology((~~: PROVIDED, That~~)). This subsection ((~~shall not be construed to~~)) does not expand a health professional's scope of practice or ((~~to~~)) allow employees of a health maintenance organization to practice as a health professional unless licensed.

(3) ((~~Nothing contained in~~)) This chapter ((~~shall~~)) does not alter any statutory obligation, or rule adopted thereunder, in chapter 70.38 ((~~or 70.39~~)) RCW.

(4) Any health maintenance organization receiving a certificate of registration pursuant to this chapter ((~~shall be~~)) is exempt from ((~~the provisions of~~)) chapter 48.05 RCW((~~, but shall be subject to chapter 70.39 RCW~~)).

Sec. 18. RCW 48.46.225 and 1990 c 119 s 4 are each amended to read as follows:

(1) Any rehabilitation, liquidation, or conservation of a health maintenance organization ((~~shall be deemed to be~~)) is the same as the rehabilitation, liquidation, or conservation of an insurance company and ((~~shall~~)) must be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080. Enrolled participants ((~~shall~~)) have the same priority in the event of

liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purposes of determining the priority of distribution of general assets, claims of enrolled participants and enrolled participants' beneficiaries ((~~shall~~)) have the same priority as established by RCW 48.31.280 for policyholders and beneficiaries of insureds of insurance companies. If an enrolled participant is liable to any provider for services provided pursuant to and covered by the health maintenance agreement, that liability ((~~shall have~~)) has the status of an enrolled participant claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled participants harmless from liability for services provided pursuant to and covered by a health care plan ((~~shall have~~)) has a priority of distribution of the general assets immediately following that of enrolled participants and enrolled participants' beneficiaries ((~~as described herein, and immediately proceeding the priority of distribution described in RCW 48.31.280(2)(e)~~)) under this section.

Sec. 19. RCW 48.46.350 and 1990 1st ex.s. c 3 s 14 are each amended to read as follows:

Each group agreement for health care services that is delivered or issued for delivery or renewed on or after January 1, 1988, ((~~shall~~)) must contain provisions providing benefits for the treatment of chemical dependency rendered to covered persons by a provider which is an "approved treatment ((~~facility or~~)) program" under RCW 70.96A.020(3)((~~: PROVIDED, That~~)). However, this section does not apply to any agreement written as supplemental coverage to any federal or state programs of health care including, but not limited to, Title XVIII health insurance for the aged ((~~(~~)), which is commonly referred to as Medicare, Parts A&B((~~)~~)), and amendments thereto. Treatment ((~~shall~~)) must be covered under the chemical dependency coverage if treatment is rendered by the health maintenance organization or if the health maintenance organization refers the enrolled participant or the enrolled participant's dependents to a physician licensed under chapter 18.57 or 18.71 RCW, or to a qualified counselor employed by an approved treatment ((~~facility or~~)) program described in RCW 70.96A.020(3). In all cases, a health maintenance organization ((~~shall~~)) retains the

right to diagnose the presence of chemical dependency and select the modality of treatment that best serves the interest of the health maintenance organization's enrolled participant, or the enrolled participant's covered dependent.

Sec. 20. RCW 48.62.111 and 1991 sp.s. c 30 s 11 are each amended to read as follows:

(1) The assets of a joint self-insurance program governed by this chapter may be invested only in accordance with the general investment authority that participating local government entities possess as a governmental entity.

(2) Except as provided in subsection (3) of this section, a joint self-insurance program may invest all or a portion of its assets by depositing the assets with the treasurer of a county within whose territorial limits any of its member local government entities lie, to be invested by the treasurer for the joint program.

(3) Local government members of a joint self-insurance program may by resolution of the program designate some other person having experience in financial or fiscal matters as treasurer of the program, if that designated treasurer is located in Washington state. The program shall, unless the program's treasurer is a county treasurer, require a bond obtained from a surety company authorized to do business in Washington in an amount and under the terms and conditions that the program finds will protect against loss arising from mismanagement or malfeasance in investing and managing program funds. The program may pay the premium on the bond.

All program funds must be paid to the treasurer and shall be disbursed by the treasurer only on warrants issued by the treasurer or a person appointed by the program and upon orders or vouchers approved by the program or as authorized under chapters 35A.40 and 42.24 RCW. The treasurer shall establish a program account, into which shall be recorded all program funds, and the treasurer shall maintain ((~~such~~)) special accounts as may be created by the program into which the treasurer shall record all money as the program may direct by resolution.

(4) The treasurer of the joint program shall deposit all program funds in a ((~~qualified~~)) public depository or depositories as defined in RCW 39.58.010(2) and under the same restrictions, contracts, and

security as provided for any participating local government entity, and ((~~such~~)) the depository shall be designated by resolution of the program.

(5) A joint self-insurance program may invest all or a portion of its assets by depositing the assets with the state investment board, to be invested by the state investment board in accordance with chapter 43.33A RCW. The state investment board shall designate a manager for those funds to whom the program may direct requests for disbursement upon orders or vouchers approved by the program or as authorized under chapters 35A.40 and 42.24 RCW.

(6) All interest and earnings collected on joint program funds belong to the program and must be deposited to the program's credit in the proper program account.

(7) A joint program may require a reasonable bond from any person handling money or securities of the program and may pay the premium for the bond.

(8) Subsections (3) and (4) of this section do not apply to a multistate joint self-insurance program governed by RCW 48.62.081.

Sec. 21. RCW 48.90.010 and 1986 c 142 s 1 are each amended to read as follows:

(1) Day care providers are facing a major crisis in that adequate and affordable business liability insurance is no longer available within this state for persons who care for children. Many child day care centers have been forced to purchase inadequate coverage at prohibitive premium rates from unregulated foreign surplus line carriers over which the state has minimal control.

(2) There is a danger that a substantial number of child day care centers who cannot afford the escalating premiums will be unable or unwilling to remain in business without adequate coverage. As a result the number of available facilities will be drastically reduced forcing some parents to leave the work force to care for their children. A corresponding demand upon the state's resources will result in the form of public assistance to unemployed parents and day care providers.

(3) There is a further danger that a substantial number of child day care centers now licensed pursuant to state law, who currently provide specific safeguards for the health and safety of children but are unable to procure insurance, may choose to continue to operate

without state approval, avoiding regulation and payment of legitimate taxes, and forcing some parents to place their children in facilities of unknown quality and questionable levels of safety.

(4) Most child day care centers are small business enterprises with limited resources. The state's policies encourage the growth and development of small businesses.

(5)(a) This chapter is intended to remedy the problem of nonexistent or unaffordable liability coverage for child day care centers, and to encourage compliance with state laws protecting children while meeting the state's sound economic policies of encouraging small business development, sustaining an active work force, and discouraging policies that result in an increased drain on the state's resources through public assistance and other forms of public funding.

(b) This chapter will empower child day care centers to create self-insurance pools, to purchase insurance coverage, and to contract for risk management and administrative services through an association with demonstrated responsible fiscal management.

((~~(6)~~)) The intent of this legislation is to allow ((~~such~~)) these associations maximum flexibility to create and administer plans to provide coverage and risk management services to licensed child day care centers.

Sec. 22. RCW 48.90.020 and 1986 c 142 s 2 are each amended to read as follows:

The definitions in this section apply throughout this chapter.

(1) "Child day care center" means an agency that regularly provides care for one or more children for periods of less than twenty-four hours as defined in RCW 74.15.020((~~(3)(d)~~)) (1)(a).

(2) "Association" means a corporation organized under Title 24 RCW, representative of one or more categories of child day care centers not formed for the sole purpose of establishing and operating a self-insurance program that:

(a) Maintains a roster of current names and addresses of member child day care centers and of former member child day care centers or their representatives, and of all employees of member or former member child day care centers;

(b) Has a membership of a size and stability to ensure that it will be able to provide consistent and responsible fiscal management; and

(c) Maintains a regular newsletter or other periodic communication to member child day care centers.

(3) "Subscriber" means a child day care center that:

(a) Subscribes to a plan created pursuant to this chapter;

(b) Complies with all state licensing requirements;

(c) Is a member in good standing of an association;

(d) Has consistently maintained its license free from revocation for cause, except where the revocation was not later rescinded or vacated by appellate or administrative decision; and

(e) Is prepared to demonstrate the willingness and ability to bear its share of the financial responsibility of its participation in the plan for each applicable contractual period.

Sec. 23. RCW 48.90.030 and 1986 c 142 s 3 are each amended to read as follows:

Associations meeting the criteria of RCW 48.90.020 are empowered to create and operate self-insurance plans to provide general liability coverage to member child day care centers who choose to subscribe to the plans.

Sec. 24. RCW 48.90.140 and 1986 c 142 s 14 are each amended to read as follows:

(1) If at any time the plan can no longer be operated on a sound financial basis, the association may elect to dissolve the plan, subject to explicit approval by the commissioner of a plan for dissolution. Once a plan operated by an association has been dissolved, that association may not again implement a plan pursuant to this chapter for five calendar years.

(2) At dissolution, the assets of the association represented by the contributing trust fund shall be deposited with the commissioner ((~~[for]~~)) for a period of twenty-one years, to be made available for claims arising during that period based upon occurrences during the term of coverage. At the time of transfer of the funds, the association shall certify to the commissioner a list of all current subscribers, with their correct mailing addresses, and shall have notified all current subscribers of their obligation to keep the

commissioner informed of any changes in their mailing addresses over the twenty-one year period, and that this obligation extends to their representatives, successors, assigns, and to the representatives of their estates. Upon dissolution, the association ((~~shall be~~)) is required to provide to the commissioner a list of all plan subscribers during all of the years of operation of the plan.

At the end of the twenty-one year period, any funds remaining in the trust account ((~~shall~~)) must be distributed to those subscribers who were current subscribers in the most recent year of operation of the plan, with each current subscriber receiving an equal share of the distribution, without regard for the length of time each child day care center was a subscriber.

In the alternative, in the discretion of the association, the balance of the contributing trust fund may be used to purchase similar or more liberal coverage from a commercial insurer. Each subscriber shall, however, be given the option to deposit its share of the fund with the commissioner as provided in this section if it elects not to participate in the proposed commercial insurance.

Sec. 25. RCW 48.99.040 and 1947 c 79 s .31.14 are each amended to read as follows:

(1) In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All ((~~such~~)) claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(2) Controverted claims belonging to claimants residing in reciprocal states may either (a) be proved in this state as provided by law, or (b)((~~,~~)) if ancillary proceedings have been commenced in ((~~such~~)) reciprocal states, ((~~may~~)) be proved in those proceedings. In the event a claimant elects to prove ((~~his~~)) a claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in RCW ((~~48.31.150~~)) 48.99.050 with respect to ancillary proceedings in this state, the final allowance of ((~~such~~)) a claim by the courts in the ancillary state ((~~shall~~)) must be accepted in this state as

conclusive as to its amount, and ((~~shall~~)) must also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

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