

CERTIFICATION OF ENROLLMENT

**HOUSE BILL 2406**

Chapter 25, Laws of 2006

59th Legislature  
2006 Regular Session

INSURANCE

EFFECTIVE DATE: 6/7/06 - Except that sections 1 through 4 become effective December 31, 2007.

Passed by the House January 18, 2006  
Yeas 96 Nays 0

FRANK CHOPP

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**Speaker of the House of Representatives**

Passed by the Senate February 28, 2006  
Yeas 45 Nays 0

BRAD OWEN

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**President of the Senate**

Approved March 9, 2006.

CHRISTINE GREGOIRE

\_\_\_\_\_  
**Governor of the State of Washington**

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 2406** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

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**Chief Clerk**

FILED

March 9, 2006 - 1:53 p.m.

**Secretary of State  
State of Washington**

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HOUSE BILL 2406

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Passed Legislature - 2006 Regular Session

State of Washington                      59th Legislature                      2006 Regular Session

By Representatives Roach and Kirby; by request of Insurance  
Commissioner

Prefiled 1/3/2006.      Read first time 01/09/2006.      Referred to  
Committee on Financial Institutions & Insurance.

1            AN ACT Relating to insurance; amending RCW 48.05.250, 48.05.440,  
2 48.43.045, 48.44.095, 48.46.080, 48.125.090, 52.30.020, 48.43.005, and  
3 48.22.030; reenacting and amending RCW 48.24.030; adding new sections  
4 to chapter 48.05 RCW; adding a new section to chapter 42.56 RCW; adding  
5 a new section to chapter 48.17 RCW; adding a new chapter to Title 43  
6 RCW; creating a new section; recodifying RCW 48.48.030, 48.48.040,  
7 48.48.045, 48.48.050, 48.48.060, 48.48.065, 48.48.070, 48.48.080,  
8 48.48.090, 48.48.110, 48.48.140, 48.48.150, and 48.48.160; repealing  
9 RCW 48.05.490 and 48.43.365; and providing an effective date.

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

11            NEW SECTION.    **Sec. 1.** A new section is added to chapter 48.05 RCW  
12 to read as follows:

13            (1) Every property and casualty insurance company doing business in  
14 this state, unless otherwise exempted by the domiciliary commissioner,  
15 shall annually submit the opinion of an appointed actuary entitled  
16 "Statement of Actuarial Opinion." This opinion shall be filed in  
17 accordance with the property and casualty annual statement instructions  
18 as adopted by the national association of insurance commissioners.

1 (2) Every property and casualty insurance company domiciled in this  
2 state that is required to submit a statement of actuarial opinion shall  
3 annually submit an actuarial opinion summary, written by the company's  
4 appointed actuary. This actuarial opinion summary shall be filed in  
5 accordance with the property and casualty annual statement instructions  
6 as adopted by the national association of insurance commissioners and  
7 shall be considered as a document supporting the actuarial opinion  
8 required in subsection (1) of this section.

9 (3) An insurance company authorized but not domiciled in this state  
10 shall provide the actuarial opinion summary upon request.

11 (4) An actuarial report and underlying work papers as required by  
12 the property and casualty annual statement instructions as adopted by  
13 the national association of insurance commissioners shall be prepared  
14 to support each actuarial opinion.

15 (5) If the insurance company fails to provide either a supporting  
16 actuarial report or work papers, or both, at the request of the  
17 commissioner or the commissioner determines that the supporting  
18 actuarial report or work papers provided by the insurance company is  
19 otherwise unacceptable to the commissioner, the commissioner may engage  
20 a qualified actuary at the expense of the company to review the opinion  
21 and the basis for the opinion and prepare the supporting actuarial  
22 report or work papers.

23 (6) The appointed actuary is not liable for damages to any person,  
24 other than the insurance company, the commissioner, or both, for any  
25 act, error, omission, decision, or conduct with respect to the  
26 actuary's opinion, except in cases of fraud or willful misconduct on  
27 the part of the appointed actuary.

28 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.05 RCW  
29 to read as follows:

30 (1) The statement of actuarial opinion shall be provided with the  
31 annual statement in accordance with the property and casualty annual  
32 statement instructions as adopted by the national association of  
33 insurance commissioners and shall be treated as a public document.

34 (2) Documents, materials or other information in the possession or  
35 control of the commissioner that are considered an actuarial report,  
36 work papers, or actuarial opinion summary provided in support of the  
37 opinion, and any other material provided by the insurance company to

1 the commissioner in connection with the actuarial report, work papers,  
2 or actuarial opinion summary, is confidential by law and privileged, is  
3 not subject to chapter 42.17 or 42.56 RCW, is not subject to subpoena,  
4 and is not subject to discovery or admissible in evidence in any  
5 private civil action.

6 (3) Subsection (2) of this section does not limit the  
7 commissioner's authority to release the documents to the actuarial  
8 board for counseling and discipline so long as the material is required  
9 for the purpose of professional disciplinary proceedings and the board  
10 establishes procedures satisfactory to the commissioner for preserving  
11 the confidentiality of the documents. Subsection (2) of this section  
12 does not limit the commissioner's authority to use the documents,  
13 materials, or other information in furtherance of any regulatory or  
14 legal action brought as part of the commissioner's official duties.

15 (4) Neither the commissioner nor any person who received documents,  
16 materials, or other information while acting under the authority of the  
17 commissioner is permitted or required to testify in any private civil  
18 action concerning any confidential documents, materials, or information  
19 subject to subsection (2) of this section.

20 (5) In order to assist in the performance of the commissioner's  
21 duties, the commissioner:

22 (a) May share documents, materials, or other information, including  
23 the confidential and privileged documents, materials, or information  
24 subject to subsection (2) of this section with other state, federal,  
25 and international regulatory agencies, with the national association of  
26 insurance commissioners and its affiliates and subsidiaries, and with  
27 state, federal, and international law enforcement authorities, provided  
28 that the recipient agrees to maintain the confidentiality and  
29 privileged status of the document, material, or other information and  
30 has the legal authority to maintain confidentiality;

31 (b) May receive documents, materials, or information, including  
32 otherwise confidential and privileged documents, materials, or  
33 information, from the national association of insurance commissioners  
34 and its affiliates and subsidiaries, and from regulatory and law  
35 enforcement officials of other foreign or domestic jurisdictions, and  
36 shall maintain as confidential or privileged any document, material, or  
37 information received with notice or the understanding that it is

1 confidential or privileged under the laws of the jurisdiction that is  
2 the source of the document, material, or information; and

3 (c) May enter into agreements governing the sharing and use of  
4 information consistent with this subsection.

5 (6) A waiver of any applicable privilege or claim of  
6 confidentiality in the documents, materials, or information may not  
7 occur as a result of disclosure to the commissioner under this section  
8 or as a result of sharing as authorized in subsection (5) of this  
9 section.

10 NEW SECTION. **Sec. 3.** A new section is added to chapter 42.56 RCW  
11 to read as follows:

12 Documents, materials, and information obtained by the insurance  
13 commissioner under section 2(2) of this act are confidential and  
14 privileged and not subject to public disclosure under this chapter.

15 NEW SECTION. **Sec. 4.** Sections 1 through 3 of this act may be  
16 known and cited as the property and casualty actuarial opinion law.

17 **Sec. 5.** RCW 48.05.250 and 1983 c 85 s 1 are each amended to read  
18 as follows:

19 (1) Each ((authorized)) domestic insurer shall annually, on or  
20 before the first day of March, file with the commissioner a true  
21 statement of its financial condition, transactions, and affairs as of  
22 the thirty-first day of December preceding. The statement forms shall  
23 be in general form and context as approved by the National Association  
24 of Insurance Commissioners for the kinds of insurance to be reported  
25 upon, and as supplemented for additional information required by this  
26 code and by the commissioner. The statement shall be verified by the  
27 oaths of at least two of the insurer's officers.

28 (2) The annual statement of an alien insurer shall relate only to  
29 its transactions and affairs in the United States unless the  
30 commissioner requires otherwise. The statement shall be verified by  
31 the insurer's United States manager or by its officers duly authorized.

32 (3) The commissioner shall suspend or revoke the certificate of  
33 authority of any insurer failing to file its annual statement when due  
34 or during any extension of time therefor which the commissioner, for  
35 good cause, may grant.

1       **Sec. 6.** RCW 48.05.440 and 1995 c 83 s 3 are each amended to read  
2 as follows:

3       (1) "Company action level event" means any of the following events:

4       (a) The filing of an RBC report by an insurer indicating that:

5       (i) The insurer's total adjusted capital is greater than or equal  
6 to its regulatory action level RBC, but less than its company action  
7 level RBC; (~~or~~)

8       (ii) If a life and disability insurer, the insurer has total  
9 adjusted capital that is greater than or equal to its company action  
10 level RBC, but less than the product of its authorized control level  
11 RBC and 2.5 and has a negative trend; or

12       (iii) If a property and casualty insurer, the insurer has total  
13 adjusted capital that is greater than or equal to its company action  
14 level RBC but less than the product of its authorized control level RBC  
15 and 3.0 and met the trend test determined in accordance with the trend  
16 test calculation included in the RBC instructions;

17       (b) The notification by the commissioner to the insurer of an  
18 adjusted RBC report that indicates an event in (a) of this subsection,  
19 provided the insurer does not challenge the adjusted RBC report under  
20 RCW 48.05.460; or

21       (c) If, under RCW 48.05.460, an insurer challenges an adjusted RBC  
22 report that indicates an event in (a) of this subsection, the  
23 notification by the commissioner to the insurer that the commissioner  
24 has, after a hearing, rejected the insurer's challenge.

25       (2) In the event of a company action level event, the insurer shall  
26 prepare and submit to the commissioner an RBC plan that:

27       (a) Identifies the conditions that contribute to the company action  
28 level event;

29       (b) Contains proposals of corrective actions that the insurer  
30 intends to take and would be expected to result in the elimination of  
31 the company action level event;

32       (c) Provides projections of the insurer's financial results in the  
33 current year and at least the four succeeding years, both in the  
34 absence of proposed corrective actions and giving effect to the  
35 proposed corrective actions, including projections of statutory  
36 operating income, net income, capital, and surplus. The projections  
37 for both new and renewal business might include separate projections

1 for each major line of business and separately identify each  
2 significant income, expense, and benefit component;

3 (d) Identifies the key assumptions impacting the insurer's  
4 projections and the sensitivity of the projections to the assumptions;  
5 and

6 (e) Identifies the quality of, and problems associated with, the  
7 insurer's business, including but not limited to its assets,  
8 anticipated business growth and associated surplus strain,  
9 extraordinary exposure to risk, mix of business, and use of  
10 reinsurance, if any, in each case.

11 (3) The RBC plan shall be submitted:

12 (a) Within forty-five days of the company action level event; or

13 (b) If the insurer challenges an adjusted RBC report under RCW  
14 48.05.460, within forty-five days after notification to the insurer  
15 that the commissioner has, after a hearing, rejected the insurer's  
16 challenge.

17 (4) Within sixty days after the submission by an insurer of an RBC  
18 plan to the commissioner, the commissioner shall notify the insurer  
19 whether the RBC plan may be implemented or is, in the judgment of the  
20 commissioner, unsatisfactory. If the commissioner determines the RBC  
21 plan is unsatisfactory, the notification to the insurer shall set forth  
22 the reasons for the determination, and may set forth proposed revisions  
23 that will render the RBC plan satisfactory. Upon notification from the  
24 commissioner, the insurer shall prepare a revised RBC plan, that may  
25 incorporate by reference any revisions proposed by the commissioner,  
26 and shall submit the revised RBC plan to the commissioner:

27 (a) Within forty-five days after the notification from the  
28 commissioner; or

29 (b) If the insurer challenges the notification from the  
30 commissioner under RCW 48.05.460, within forty-five days after a  
31 notification to the insurer that the commissioner has, after a hearing,  
32 rejected the insurer's challenge.

33 (5) In the event of a notification by the commissioner to an  
34 insurer that the insurer's RBC plan or revised RBC plan is  
35 unsatisfactory, the commissioner may, subject to the insurer's rights  
36 to a hearing under RCW 48.05.460, specify in the notification that the  
37 notification constitutes a regulatory action level event.

1 (6) Every domestic insurer that files an RBC plan or revised RBC  
2 plan with the commissioner shall file a copy of the RBC plan or revised  
3 RBC plan with the insurance commissioner in any state in which the  
4 insurer is authorized to do business if:

5 (a) The state has an RBC provision substantially similar to RCW  
6 48.05.465(1); and

7 (b) The insurance commissioner of that state has notified the  
8 insurer of its request for the filing in writing, in which case the  
9 insurer shall file a copy of the RBC plan or revised RBC plan in that  
10 state no later than the later of:

11 (i) Fifteen days after the receipt of notice to file a copy of its  
12 RBC plan or revised plan with the state; or

13 (ii) The date on which the RBC plan or revised RBC plan is filed  
14 under subsections (3) and (4) of this section.

15 **Sec. 7.** RCW 48.43.045 and 1997 c 231 s 205 are each amended to  
16 read as follows:

17 Every health plan delivered, issued for delivery, or renewed by a  
18 health carrier on and after January 1, 1996, shall:

19 (1) Permit every category of health care provider to provide health  
20 services or care for conditions included in the basic health plan  
21 services to the extent that:

22 (a) The provision of such health services or care is within the  
23 health care providers' permitted scope of practice; and

24 (b) The providers agree to abide by standards related to:

25 (i) Provision, utilization review, and cost containment of health  
26 services;

27 (ii) Management and administrative procedures; and

28 (iii) Provision of cost-effective and clinically efficacious health  
29 services.

30 (2) Annually report the names and addresses of all officers,  
31 directors, or trustees of the health carrier during the preceding year,  
32 and the amount of wages, expense reimbursements, or other payments to  
33 such individuals, unless substantially similar information is filed  
34 with the commissioner or the national association of insurance  
35 commissioners. This requirement does not apply to a foreign or alien  
36 insurer regulated under chapter 48.20 or 48.21 RCW that files a



1 supplemental compensation exhibit in its annual statement as required  
2 by law.

3 **Sec. 8.** RCW 48.44.095 and 1997 c 212 s 4 are each amended to read  
4 as follows:

5 (1) Every domestic health care service contractor shall annually,  
6 on or before the first day of March, file with the commissioner a  
7 statement verified by at least two of the principal officers of the  
8 health care service contractor showing its financial condition as of  
9 the last day of the preceding calendar year. The statement shall be in  
10 such form as is furnished or prescribed by the commissioner. The  
11 commissioner may for good reason allow a reasonable extension of the  
12 time within which such annual statement shall be filed.

13 (2) In addition to the requirements of subsection (1) of this  
14 section, every health care service contractor that is registered in  
15 this state shall annually, on or before March 1st of each year, file  
16 with the national association of insurance commissioners a copy of its  
17 annual statement, along with those additional schedules as prescribed  
18 by the commissioner for the preceding year. The information filed with  
19 the national association of insurance commissioners shall be in the  
20 same format and scope as that required by the commissioner and shall  
21 include the signed jurate page and the actuarial certification. Any  
22 amendments and addendums to the annual statement filing subsequently  
23 filed with the commissioner shall also be filed with the national  
24 association of insurance commissioners.

25 (3) Coincident with the filing of its annual statement and other  
26 schedules, each health care service contractor shall pay a reasonable  
27 fee directly to the national association of insurance commissioners in  
28 an amount approved by the commissioner to cover the costs associated  
29 with the analysis of the annual statement.

30 (4) Foreign health care service contractors that are domiciled in  
31 a state that has a law substantially similar to subsection (2) of this  
32 section are considered to be in compliance with this section.

33 (5) In the absence of actual malice, members of the national  
34 association of insurance commissioners, their duly authorized  
35 committees, subcommittees, and task forces, their delegates, national  
36 association of insurance commissioners employees, and all other persons  
37 charged with the responsibility of collecting, reviewing, analyzing,

1 and dissimilating the information developed from the filing of the  
2 annual statement shall be acting as agents of the commissioner under  
3 the authority of this section and shall not be subject to civil  
4 liability for libel, slander, or any other cause of action by virtue of  
5 their collection, review, analysis, or dissimulation of the data and  
6 information collected for the filings required under this section.

7 (6) The commissioner may suspend or revoke the certificate of  
8 registration of any health care service contractor failing to file its  
9 annual statement or pay the fees when due or during any extension of  
10 time therefor which the commissioner, for good cause, may grant.

11 **Sec. 9.** RCW 48.46.080 and 1997 c 212 s 5 are each amended to read  
12 as follows:

13 (1) Every domestic health maintenance organization shall annually,  
14 on or before the first day of March, file with the commissioner a  
15 statement verified by at least two of the principal officers of the  
16 health maintenance organization showing its financial condition as of  
17 the last day of the preceding calendar year.

18 (2) Such annual report shall be in such form as the commissioner  
19 shall prescribe and shall include:

20 (a) A financial statement of such organization, including its  
21 balance sheet and receipts and disbursements for the preceding year,  
22 which reflects at a minimum;

23 (i) All prepayments and other payments received for health care  
24 services rendered pursuant to health maintenance agreements;

25 (ii) Expenditures to all categories of health care facilities,  
26 providers, insurance companies, or hospital or medical service plan  
27 corporations with which such organization has contracted to fulfill  
28 obligations to enrolled participants arising out of its health  
29 maintenance agreements, together with all other direct expenses  
30 including depreciation, enrollment, and commission; and

31 (iii) Expenditures for capital improvements, or additions thereto,  
32 including but not limited to construction, renovation, or purchase of  
33 facilities and capital equipment;

34 (b) The number of participants enrolled and terminated during the  
35 report period. Every employer offering health care benefits to their  
36 employees through a group contract with a health maintenance

1 organization shall furnish said health maintenance organization with a  
2 list of their employees enrolled under such plan;

3 (c) The number of doctors by type of practice who, under contract  
4 with or as an employee of the health maintenance organization,  
5 furnished health care services to consumers during the past year;

6 (d) A report of the names and addresses of all officers, directors,  
7 or trustees of the health maintenance organization during the preceding  
8 year, and the amount of wages, expense reimbursements, or other  
9 payments to such individuals for services to such organization. For  
10 partnership and professional service corporations, a report shall be  
11 made for partners or shareholders as to any compensation or expense  
12 reimbursement received by them for services, other than for services  
13 and expenses relating directly for patient care;

14 (e) Such other information relating to the performance of the  
15 health maintenance organization or the health care facilities or  
16 providers with which it has contracted as reasonably necessary to the  
17 proper and effective administration of this chapter, in accordance with  
18 rules and regulations; and

19 (f) Disclosure of any financial interests held by officers and  
20 directors in any providers associated with the health maintenance  
21 organization or any provider of the health maintenance organization.

22 (3) The commissioner may for good reason allow a reasonable  
23 extension of the time within which such annual statement shall be  
24 filed.

25 (4) In addition to the requirements of subsections (1) and (2) of  
26 this section, every health maintenance organization that is registered  
27 in this state shall annually, on or before March 1st of each year, file  
28 with the national association of insurance commissioners a copy of its  
29 annual statement, along with those additional schedules as prescribed  
30 by the commissioner for the preceding year. The information filed with  
31 the national association of insurance commissioners shall be in the  
32 same format and scope as that required by the commissioner and shall  
33 include the signed jurate page and the actuarial certification. Any  
34 amendments and addendums to the annual statement filing subsequently  
35 filed with the commissioner shall also be filed with the national  
36 association of insurance commissioners.

37 (5) Coincident with the filing of its annual statement and other  
38 schedules, each health maintenance organization shall pay a reasonable

1 fee directly to the national association of insurance commissioners in  
2 an amount approved by the commissioner to cover the costs associated  
3 with the analysis of the annual statement.

4 (6) Foreign health maintenance organizations that are domiciled in  
5 a state that has a law substantially similar to subsection (4) of this  
6 section are considered to be in compliance with this section.

7 (7) In the absence of actual malice, members of the national  
8 association of insurance commissioners, their duly authorized  
9 committees, subcommittees, and task forces, their delegates, national  
10 association of insurance commissioners employees, and all other persons  
11 charged with the responsibility of collecting, reviewing, analyzing,  
12 and disseminating the information developed from the filing of the  
13 annual statement shall be acting as agents of the commissioner under  
14 the authority of this section and shall not be subject to civil  
15 liability for libel, slander, or any other cause of action by virtue of  
16 their collection, review, analysis, or dissemination of the data and  
17 information collected for the filings required under this section.

18 (8) The commissioner may suspend or revoke the certificate of  
19 registration of any health maintenance organization failing to file its  
20 annual statement or pay the fees when due or during any extension of  
21 time therefor which the commissioner, for good cause, may grant.

22 (9) No person shall knowingly file with any public official or  
23 knowingly make, publish, or disseminate any financial statement of a  
24 health maintenance organization which does not accurately state the  
25 health maintenance organization's financial condition.

26 **Sec. 10.** RCW 48.125.090 and 2004 c 260 s 11 are each amended to  
27 read as follows:

28 (1) A self-funded multiple employer welfare arrangement must comply  
29 with the reporting requirements of this section.

30 (2) Every arrangement holding a certificate of authority from the  
31 commissioner must file its financial statements as required by this  
32 title and by the commissioner in accordance with the accounting  
33 practices and procedures manuals as adopted by the national association  
34 of insurance commissioners, unless otherwise provided by law.

35 (3) Every arrangement must comply with the provisions of chapters  
36 48.12 and 48.13 RCW.

1 (4) Every domestic arrangement holding a certificate of authority  
2 shall((~~τ~~)) annually, on or before the first day of March, file with the  
3 commissioner a true statement of its financial condition, transactions,  
4 and affairs as of the thirty-first day of December of the preceding  
5 year. The statement forms must be those forms approved by the national  
6 association of insurance commissioners for health insurance. The  
7 statement must be verified by the oaths of at least two officers of the  
8 arrangement. Additional information may be required by this title or  
9 by the request of the commissioner.

10 (5) Every arrangement must report their annual and other statements  
11 in the same manner required of other insurers by rule of the  
12 commissioner.

13 (6) The arrangement must file with the commissioner a copy of the  
14 arrangement's internal revenue service form 5500 together with all  
15 attachments to the form, at the time required for filing the form.

16 NEW SECTION. **Sec. 11.** The following acts or parts of acts are  
17 each repealed:

18 (1) RCW 48.05.490 (RBC reports for 1995--Requirements) and 1995 c  
19 83 s 13; and

20 (2) RCW 48.43.365 (RBC report for 1998 calendar year) and 1998 c  
21 241 s 14.

22 **Sec. 12.** RCW 52.30.020 and 1979 c 151 s 164 are each amended to  
23 read as follows:

24 Wherever a fire protection district has been organized which  
25 includes within its area or is adjacent to, buildings and equipment,  
26 except those leased to a nontax exempt person or organization, owned by  
27 the legislative or administrative authority of a state agency or  
28 institution or a municipal corporation, the agency or institution or  
29 municipal corporation involved shall contract with such district for  
30 fire protection services necessary for the protection and safety of  
31 personnel and property pursuant to the provisions of chapter 39.34  
32 RCW(~~(, as now or hereafter amended)~~): PROVIDED, That nothing in this  
33 section shall be construed to require that any state agency,  
34 institution, or municipal corporation contract for services which are  
35 performed by the staff and equipment of such state agency, institution,  
36 or municipal corporation: PROVIDED FURTHER, That nothing in this

1 section shall apply to state agencies or institutions or municipal  
2 corporations which are receiving fire protection services by contract  
3 from another municipality, city, town, or other entities: AND PROVIDED  
4 FURTHER, That school districts shall receive fire protection services  
5 from the fire protection districts in which they are located without  
6 the necessity of executing a contract for such fire protection  
7 services: PROVIDED FURTHER, That prior to September 1, 1974, the  
8 superintendent of public instruction, the (~~insurance commissioner~~)  
9 chief of the Washington state patrol through the director of fire  
10 protection, the director of financial management, and the executive  
11 director of the Washington fire commissioners association, or their  
12 designees, shall develop criteria to be used by the (~~insurance~~  
13 ~~commissioner~~) chief of the Washington state patrol through the  
14 director of fire protection in establishing uniform rates governing  
15 payments to fire districts by school districts for fire protection  
16 services. On or before September 1, 1974, the (~~insurance~~  
17 ~~commissioner~~) chief of the Washington state patrol through the  
18 director of fire protection shall establish such rates to be payable by  
19 school districts on or before January 1st of each year commencing  
20 January 1, 1975, payable July 1, 1975: AND PROVIDED FURTHER, That  
21 beginning with the 1975-77 biennium and in each biennium thereafter the  
22 superintendent of public instruction shall present in (~~his~~) the  
23 budget submittal to the governor an amount sufficient to reimburse  
24 affected school districts for the moneys necessary to pay the costs of  
25 the uniform rates established by the (~~insurance commissioner~~) chief  
26 of the Washington state patrol through the director of fire protection.

27 NEW SECTION. Sec. 13. RCW 48.48.030, 48.48.040, 48.48.045,  
28 48.48.050, 48.48.060, 48.48.065, 48.48.070, 48.48.080, 48.48.090,  
29 48.48.110, 48.48.140, 48.48.150, and 48.48.160 are each recodified as  
30 a new chapter in Title 43 RCW.

31 **Sec. 14.** RCW 48.24.030 and 2005 c 223 s 13 and 2005 c 222 s 2 are  
32 each reenacted and amended to read as follows:

33 (1) Insurance under any group life insurance policy issued under  
34 RCW 48.24.020, 48.24.050, 48.24.060, 48.24.070, or 48.24.090 may be  
35 extended to insure the spouse and dependent children, or any class or  
36 classes thereof, of each insured employee or member who so elects, in

1 amounts in accordance with a plan that precludes individual selection  
2 by the employees or members or by the employer or labor union or  
3 trustee, and which insurance on the life of any one family member  
4 including a spouse shall not be in excess of the amount on the life of  
5 the insured employee or member.

6 Premiums for the insurance on the family members shall be paid by  
7 the policyholder, either from the employer's funds, funds contributed  
8 to him or her, employee's funds, trustee's funds, or labor union funds.

9 (2) A spouse insured under this section has the same conversion  
10 right as to the insurance on his or her life as is vested in the  
11 employee or member under this chapter.

12 NEW SECTION. **Sec. 15.** A new section is added to chapter 48.17 RCW  
13 to read as follows:

14 (1) All Washington state licensed insurance agents who sell federal  
15 flood insurance policies must comply with the minimum training  
16 requirements of section 207 of the flood insurance reform act of 2004,  
17 and basic flood education as outlined at 70 C.F.R. Sec. 52117, or such  
18 later requirements as are published by the federal emergency management  
19 agency.

20 (2) Licensed insurers shall demonstrate to the commissioner, upon  
21 request, that their licensed and appointed agents who sell federal  
22 flood insurance policies have complied with the minimum federal flood  
23 insurance training requirements.

24 **Sec. 16.** RCW 48.43.005 and 2004 c 244 s 2 are each amended to read  
25 as follows:

26 Unless otherwise specifically provided, the definitions in this  
27 section apply throughout this chapter.

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

32 (2) "Basic health plan" means the plan described under chapter  
33 70.47 RCW, as revised from time to time.

34 (3) "Basic health plan model plan" means a health plan as required  
35 in RCW 70.47.060(2)((~~d~~)) (e).

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

5 (5) "Catastrophic health plan" means:

6 (a) In the case of a contract, agreement, or policy covering a  
7 single enrollee, a health benefit plan requiring a calendar year  
8 deductible of, at a minimum, one thousand five hundred dollars and an  
9 annual out-of-pocket expense required to be paid under the plan (other  
10 than for premiums) for covered benefits of at least three thousand  
11 dollars; and

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

18 (c) Any health benefit plan that provides benefits for hospital  
19 inpatient and outpatient services, professional and prescription drugs  
20 provided in conjunction with such hospital inpatient and outpatient  
21 services, and excludes or substantially limits outpatient physician  
22 services and those services usually provided in an office setting.

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

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

31 (8) "Covered person" or "enrollee" means a person covered by a  
32 health plan including an enrollee, subscriber, policyholder,  
33 beneficiary of a group plan, or individual covered by any other health  
34 plan.

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



1 (10) "Eligible employee" means an employee who works on a full-time  
2 basis with a normal work week of thirty or more hours. The term  
3 includes a self-employed individual, including a sole proprietor, a  
4 partner of a partnership, and may include an independent contractor, if  
5 the self-employed individual, sole proprietor, partner, or independent  
6 contractor is included as an employee under a health benefit plan of a  
7 small employer, but does not work less than thirty hours per week and  
8 derives at least seventy-five percent of his or her income from a trade  
9 or business through which he or she has attempted to earn taxable  
10 income and for which he or she has filed the appropriate internal  
11 revenue service form. Persons covered under a health benefit plan  
12 pursuant to the consolidated omnibus budget reconciliation act of 1986  
13 shall not be considered eligible employees for purposes of minimum  
14 participation requirements of chapter 265, Laws of 1995.

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

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

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

29 (14) "Grievance" means a written complaint submitted by or on  
30 behalf of a covered person regarding: (a) Denial of payment for  
31 medical services or nonprovision of medical services included in the  
32 covered person's health benefit plan, or (b) service delivery issues  
33 other than denial of payment for medical services or nonprovision of  
34 medical services, including dissatisfaction with medical care, waiting  
35 time for medical services, provider or staff attitude or demeanor, or  
36 dissatisfaction with service provided by the health carrier.

37 (15) "Health care facility" or "facility" means hospices licensed  
38 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,

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

12 (16) "Health care provider" or "provider" means:

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

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

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

21 (18) "Health carrier" or "carrier" means a disability insurer  
22 regulated under chapter 48.20 or 48.21 RCW, a health care service  
23 contractor as defined in RCW 48.44.010, or a health maintenance  
24 organization as defined in RCW 48.46.020.

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

28 (a) Long-term care insurance governed by chapter 48.84 RCW;

29 (b) Medicare supplemental health insurance governed by chapter  
30 48.66 RCW;

31 (c) Coverage supplemental to the coverage provided under chapter  
32 55, Title 10, United States Code;

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

35 (~~(d)~~) (e) Disability income;

36 (~~(e)~~) (f) Coverage incidental to a property/casualty liability  
37 insurance policy such as automobile personal injury protection coverage  
38 and homeowner guest medical;

1       ~~((f))~~ (g) Workers' compensation coverage;  
2       ~~((g))~~ (h) Accident only coverage;  
3       ~~((h))~~ (i) Specified disease and hospital confinement indemnity  
4 when marketed solely as a supplement to a health plan;  
5       ~~((i))~~ (j) Employer-sponsored self-funded health plans;  
6       ~~((j))~~ (k) Dental only and vision only coverage; and  
7       ~~((k))~~ (l) Plans deemed by the insurance commissioner to have a  
8 short-term limited purpose or duration, or to be a student-only plan  
9 that is guaranteed renewable while the covered person is enrolled as a  
10 regular full-time undergraduate or graduate student at an accredited  
11 higher education institution, after a written request for such  
12 classification by the carrier and subsequent written approval by the  
13 insurance commissioner.

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

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

20       (22) "Premium" means all sums charged, received, or deposited by a  
21 health carrier as consideration for a health plan or the continuance of  
22 a health plan. Any assessment or any "membership," "policy,"  
23 "contract," "service," or similar fee or charge made by a health  
24 carrier in consideration for a health plan is deemed part of the  
25 premium. "Premium" shall not include amounts paid as enrollee point-  
26 of-service cost-sharing.

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

32       (24) "Small employer" or "small group" means any person, firm,  
33 corporation, partnership, association, political subdivision, sole  
34 proprietor, or self-employed individual that is actively engaged in  
35 business that, on at least fifty percent of its working days during the  
36 preceding calendar quarter, employed at least two but no more than  
37 fifty eligible employees, with a normal work week of thirty or more  
38 hours, the majority of whom were employed within this state, and is not

1 formed primarily for purposes of buying health insurance and in which  
2 a bona fide employer-employee relationship exists. In determining the  
3 number of eligible employees, companies that are affiliated companies,  
4 or that are eligible to file a combined tax return for purposes of  
5 taxation by this state, shall be considered an employer. Subsequent to  
6 the issuance of a health plan to a small employer and for the purpose  
7 of determining eligibility, the size of a small employer shall be  
8 determined annually. Except as otherwise specifically provided, a  
9 small employer shall continue to be considered a small employer until  
10 the plan anniversary following the date the small employer no longer  
11 meets the requirements of this definition. A self-employed individual  
12 or sole proprietor must derive at least seventy-five percent of his or  
13 her income from a trade or business through which the individual or  
14 sole proprietor has attempted to earn taxable income and for which he  
15 or she has filed the appropriate internal revenue service form 1040,  
16 schedule C or F, for the previous taxable year except for a self-  
17 employed individual or sole proprietor in an agricultural trade or  
18 business, who must derive at least fifty-one percent of his or her  
19 income from the trade or business through which the individual or sole  
20 proprietor has attempted to earn taxable income and for which he or she  
21 has filed the appropriate internal revenue service form 1040, for the  
22 previous taxable year. A self-employed individual or sole proprietor  
23 who is covered as a group of one on the day prior to June 10, 2004,  
24 shall also be considered a "small employer" to the extent that  
25 individual or group of one is entitled to have his or her coverage  
26 renewed as provided in RCW 48.43.035(6).

27 (25) "Utilization review" means the prospective, concurrent, or  
28 retrospective assessment of the necessity and appropriateness of the  
29 allocation of health care resources and services of a provider or  
30 facility, given or proposed to be given to an enrollee or group of  
31 enrollees.

32 (26) "Wellness activity" means an explicit program of an activity  
33 consistent with department of health guidelines, such as, smoking  
34 cessation, injury and accident prevention, reduction of alcohol misuse,  
35 appropriate weight reduction, exercise, automobile and motorcycle  
36 safety, blood cholesterol reduction, and nutrition education for the  
37 purpose of improving enrollee health status and reducing health service  
38 costs.

1           **Sec. 17.** RCW 48.22.030 and 2004 c 90 s 1 are each amended to read  
2 as follows:

3           (1) "Underinsured motor vehicle" means a motor vehicle with respect  
4 to the ownership, maintenance, or use of which either no bodily injury  
5 or property damage liability bond or insurance policy applies at the  
6 time of an accident, or with respect to which the sum of the limits of  
7 liability under all bodily injury or property damage liability bonds  
8 and insurance policies applicable to a covered person after an accident  
9 is less than the applicable damages which the covered person is legally  
10 entitled to recover.

11           (2) No new policy or renewal of an existing policy insuring against  
12 loss resulting from liability imposed by law for bodily injury, death,  
13 or property damage, suffered by any person arising out of the  
14 ownership, maintenance, or use of a motor vehicle shall be issued with  
15 respect to any motor vehicle registered or principally garaged in this  
16 state unless coverage is provided therein or supplemental thereto for  
17 the protection of persons insured thereunder who are legally entitled  
18 to recover damages from owners or operators of underinsured motor  
19 vehicles, hit-and-run motor vehicles, and phantom vehicles because of  
20 bodily injury, death, or property damage, resulting therefrom, except  
21 while operating or occupying a motorcycle or motor-driven cycle, and  
22 except while operating or occupying a motor vehicle owned or available  
23 for the regular use by the named insured or any family member, and  
24 which is not insured under the liability coverage of the policy. The  
25 coverage required to be offered under this chapter is not applicable to  
26 general liability policies, commonly known as umbrella policies, or  
27 other policies which apply only as excess to the insurance directly  
28 applicable to the vehicle insured.

29           (3) Except as to property damage, coverage required under  
30 subsection (2) of this section shall be in the same amount as the  
31 insured's third party liability coverage unless the insured rejects all  
32 or part of the coverage as provided in subsection (4) of this section.  
33 Coverage for property damage need only be issued in conjunction with  
34 coverage for bodily injury or death. Property damage coverage required  
35 under subsection (2) of this section shall mean physical damage to the  
36 insured motor vehicle unless the policy specifically provides coverage  
37 for the contents thereof or other forms of property damage.

1 (4) A named insured or spouse may reject, in writing, underinsured  
2 coverage for bodily injury or death, or property damage, and the  
3 requirements of subsections (2) and (3) of this section shall not  
4 apply. If a named insured or spouse has rejected underinsured  
5 coverage, such coverage shall not be included in any supplemental or  
6 renewal policy unless a named insured or spouse subsequently requests  
7 such coverage in writing. The requirement of a written rejection under  
8 this subsection shall apply only to the original issuance of policies  
9 issued after July 24, 1983, and not to any renewal or replacement  
10 policy. When a named insured or spouse chooses a property damage  
11 coverage that is less than the insured's third party liability coverage  
12 for property damage, a written rejection is not required.

13 (5) The limit of liability under the policy coverage may be defined  
14 as the maximum limits of liability for all damages resulting from any  
15 one accident regardless of the number of covered persons, claims made,  
16 or vehicles or premiums shown on the policy, or premiums paid, or  
17 vehicles involved in an accident.

18 (6) The policy may provide that if an injured person has other  
19 similar insurance available to him under other policies, the total  
20 limits of liability of all coverages shall not exceed the higher of the  
21 applicable limits of the respective coverages.

22 (7)(a) The policy may provide for a deductible of not more than  
23 three hundred dollars for payment for property damage when the damage  
24 is caused by a hit-and-run driver or a phantom vehicle.

25 (b) In all other cases of underinsured property damage coverage,  
26 the policy may provide for a deductible of not more than one hundred  
27 dollars.

28 (8) For the purposes of this chapter, a "phantom vehicle" shall  
29 mean a motor vehicle which causes bodily injury, death, or property  
30 damage to an insured and has no physical contact with the insured or  
31 the vehicle which the insured is occupying at the time of the accident  
32 if:

33 (a) The facts of the accident can be corroborated by competent  
34 evidence other than the testimony of the insured or any person having  
35 an underinsured motorist claim resulting from the accident; and

36 (b) The accident has been reported to the appropriate law  
37 enforcement agency within seventy-two hours of the accident.

1           (9) An insurer who elects to write motorcycle or motor-driven cycle  
2 insurance in this state must provide information to prospective  
3 insureds about the coverage.

4           NEW SECTION.   **Sec. 18.** Sections 1 through 4 of this act take  
5 effect December 31, 2007.

        Passed by the House January 18, 2006.

        Passed by the Senate February 28, 2006.

        Approved by the Governor March 9, 2006.

        Filed in Office of Secretary of State March 9, 2006.