S-4566.1

SUBSTITUTE SENATE BILL 6248

State of Washington 69th Legislature 2026 Regular Session

By Senate Business, Trade & Economic Development (originally sponsored by Senators Stanford, Dozier, Hasegawa, Kauffman, and Nobles)

READ FIRST TIME 02/04/26.

AN ACT Relating to travel insurance; amending RCW 48.17.060 and 48.43.005; adding a new section to chapter 48.30 RCW; adding a new chapter to Title 48 RCW; and providing an effective date.

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

NEW SECTION. **Sec. 1.** (1) The purpose of this chapter is to promote the public welfare by creating a comprehensive legal framework within which travel insurance may be sold in this state.

(2) The requirements of this chapter:

(a) Apply to travel insurance that covers any resident of this state, and is sold, solicited, negotiated, or offered in this state, and policies and certificates that are delivered or issued for delivery in this state; and

(b) Do not apply to cancellation fee waivers or travel assistance services, except as expressly provided in this chapter.

(3) All other applicable provisions of this state's insurance laws, under this title, continue to apply to travel insurance, except that in the event of a conflict between this chapter and other provisions of this title regarding travel insurance and travel protection plans, the provisions of this chapter control.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(2) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(3) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

(4) "Eligible group" means two or more persons who are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship including, but not limited to, any of the following:

(a) Any entity engaged in the business of providing travel or travel services including, but not limited to: Tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers or the operator, owner, or lessor of a means of transportation of passengers including, but not limited to, airlines, cruise lines, railroads, steamship companies, and public bus carriers, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to such travel;

(b) Any college, school, or other institution of learning, covering students, teachers, employees, or volunteers;

(c) Any employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests;

(d) Any sports team, camp, or sponsor thereof, covering participants, members, campers, employees, officials, supervisors, or volunteers;

(e) Any religious, charitable, recreational, educational, or civic organization, or branch thereof, covering any group of members, participants, or volunteers;

(f) Any financial institution or financial institution vendor, or parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including account holders, credit card holders, debtors, guarantors, or purchasers;

(g) Any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association covering its members;

(h) Any trust or the trustees of a fund established, created, or maintained for the benefit of and covering members, employees, or customers, subject to the commissioner permitting the use of a trust and the state's premium tax provisions in section 4 of this act of one or more associations meeting the requirements of (g) of this subsection;

(i) Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

(j) Any volunteer fire department, ambulance, rescue, police, court, or any first aid, civil defense, or other such volunteer group;

(k) Preschools, day care institutions for children or adults, and senior citizen clubs;

(l) Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles, subject to the requirement that the common carrier, operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company, is the policyholder under a policy to which this chapter applies; or

(m) Any other group where the commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest.

(5) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and

providing the travel protection plan's coverage and assistance details.

(6) "Group travel insurance" means travel insurance issued to any eligible group.

(7) "Limited lines travel insurance producer" means a:

(a) Licensed insurance producer, including a licensed limited lines producer of travel insurance; or

(b) Travel administrator.

(8) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application and collecting premiums.

(9) "Primary certificate holder" means an individual person who elects and purchases travel insurance under a group policy.

(10) "Primary policyholder" means an individual person who elects and purchases individual travel insurance.

(11) "Travel administrator" means a person who directly or indirectly underwrites, collects charges, collateral, or premiums from, or adjusts or settles claims on residents of this state, in connection with travel insurance, except that a person may not be considered a travel administrator if that person's only actions that would otherwise cause it to be considered a travel administrator are among the following:

(a) A person working for a travel administrator to the extent that the person's activities are subject to the supervision and control of the travel administrator;

(b) An insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the producer's license;

(c) A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with this chapter;

(d) An attorney-at-law who adjusts insurance losses from time to time incidental to the practice of their profession and who does not collect charges or premiums in connection with insurance coverage; or

(e) A business entity that is affiliated with an authorized insurer while acting as a travel administrator for the direct and assumed insurance business of an insurer.

(12) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event,

and where providing the service does not result in transfer or shifting of risk that would constitute the business of insurance.

(a) "Travel assistance services" include, but are not limited to: Security advisories, destination information, vaccination and immunization information services, travel reservation services, entertainment, activity and event planning, translation assistance, emergency messaging, international legal and medical referrals, medical case monitoring, coordination of transportation arrangements, emergency cash transfer assistance, medical prescription replacement assistance, passport and travel document replacement assistance, lost luggage assistance, concierge services, and any other service that is furnished in connection with planned travel.

(b) "Travel assistance services" are not insurance and not related to insurance.

(13)(a) "Travel insurance" means, except as excluded in (b) of this subsection, insurance coverage for personal risks incident to planned travel, including:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damages to accommodations or rental vehicles;

(iv) Sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage;

(v) Emergency evacuation;

(vi) Repatriation of remains; or

(vii) Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the commissioner.

(b) "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six months including, for example, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

(14) "Travel protection plans" means plans that provide one or more of the following: Travel insurance, travel assistance services, and cancellation fee waivers.

(15) "Travel retailer" means a business entity that makes, arranges, or offers planned travel and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

NEW SECTION. **Sec. 3.** (1) In accordance with RCW 48.17.170, the commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed with the commissioner an application for a limited lines travel insurance producer license in a form and manner prescribed by the commissioner. Such limited lines travel insurance producer must be licensed to sell, solicit, or negotiate travel insurance through an authorized insurer. No person may act as a limited lines travel insurance producer or travel insurance retailer unless properly licensed or registered, respectively.

(2) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(a) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(i) A description of the material terms or the actual material terms of the insurance coverage;

(ii) A description of the process for filing a claim;

(iii) A description of the review or cancellation process for the travel insurance policy; and

(iv) The identity and contact information of the insurer and limited lines travel insurance producer;

(b) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register, on a form prescribed by the commissioner, of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register must be maintained and updated by the limited lines travel insurance producer and must include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the commissioner annually in a form and manner prescribed by the commissioner. The limited lines travel insurance producer shall certify that the travel retailer registered complies with 18 U.S.C. Sec. 1033. The grounds for the suspension, revocation, and penalties applicable to resident insurance producers under RCW 48.17.530 and 48.17.535 apply to the limited lines travel insurance producers and travel retailers;

(c) The limited lines travel insurance producer has designated one of its employees who is a licensed individual producer as the person responsible for the compliance with the travel insurance laws and regulations applicable to the limited lines travel insurance producer and its registrants;

(d) The employee designated under (c) of this subsection, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations complies with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

(e) The limited lines travel insurance producer has paid all applicable licensing fees as set forth in applicable state law; and

(f) The limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which is subject, at the discretion of the commissioner, to review and approval. The training material must, at a minimum, contain adequate instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(3) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that have been approved by the travel insurer. Such materials must include information that, at a minimum:

(a) Provides the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) Explains that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(c) Explains that a travel retailer who is not licensed as a limited lines travel insurance producer is permitted to provide only general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(4) A travel retailer employee or authorized representative who is not licensed as a limited lines travel insurance producer may not:

(a) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(b) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(c) Represent or otherwise indicate that the employee or authorized representative is an authorized insurer, licensed producer, or insurance expert.

(5) Notwithstanding any other provision in law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this chapter, is authorized to receive related compensation, upon registration by the limited lines travel insurance producer as described in subsection (2)(b) of this section.

(6) As the insurer's designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall ensure compliance by the travel retailer with this chapter.

(7) The limited lines travel insurance producer is responsible under the insurance code for any acts committed by any unlicensed persons that violate the insurance code under the limited lines travel insurance producer's or travel retailer's supervision, control, or direction. The commissioner may enforce the provisions of this title against the limited lines travel insurance producer or travel retailer for any such acts.

NEW SECTION. **Sec. 4.** (1) A travel insurer shall pay premium tax as provided in RCW 48.14.020 on travel insurance premiums paid by any of the following:

(a) An individual primary policyholder who is a resident of this state;

(b) A primary certificate holder who is a resident of this state who elects coverage under a group travel insurance policy; or

(c) A blanket travel insurance policyholder that is a resident in, or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in this state for eligible blanket group members, subject to any apportionment rules that apply to the insurer across multiple taxing jurisdictions or that permit the insurer to allocate

premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(2) A travel insurer shall:

(a) Document the state of residence or principal place of business of the policyholder or certificate holder, as required in subsection (1) of this section; and

(b) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services, cancellation fee waivers, or other noninsurance services.

NEW SECTION. **Sec. 5.** Travel protection plans may be offered for one price for the combined features that the travel protection plan offers in this state if:

(1) The travel protection plan clearly discloses to the consumer, at or prior to the time of purchase, that it includes travel insurance, travel assistance services, and cancellation fee waivers as applicable, and provides information and an opportunity, at or prior to the time of purchase, for the consumer to obtain additional information regarding the features and pricing of each; and

(2) The fulfillment materials:

(a) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(b) Include the travel insurance disclosures and the contact information for persons providing travel assistance services, and cancellation fee waivers, as applicable.

NEW SECTION. **Sec. 6.** (1) All persons offering travel insurance to residents of this state are subject to chapter 48.30 RCW, except as otherwise provided in this section. In the event of a conflict between this chapter and other provisions of this title regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this chapter control.

(2) Pursuant to section 12 of this act, offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under chapter 48.30 RCW.

(3) The marketing requirements in this subsection apply to travel insurance.

(a) All documents provided to consumers prior to the purchase of travel insurance including, but not limited to, sales materials, advertising materials, and marketing materials, must be consistent with the travel insurance policy itself including, but not limited to, forms, endorsements, policies, rate filings, and certificates of insurance.

(b) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions must be provided any time prior to the time of purchase, and in the coverage's fulfillment materials.

(c) The fulfillment materials and the information described in section 3(2)(a) of this act must be provided to a policyholder or certificate holder as soon as practicable, following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least: (i) 15 days following the date of delivery of the travel protection plan's fulfillment materials by postal mail; or (ii) 10 days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail. For the purposes of this subsection, "delivery" means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by postal mail or electronic means to the policyholder or certificate holder.

(d) The company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(e) Where travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it is not an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

(4) No person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage, such as

unchecking a box on an electronic form, when the consumer purchases a trip.

(5) Pursuant to section 12 of this act, it is an unfair trade practice to market blanket travel insurance coverage as free.

(6) Where a consumer's destination jurisdiction requires insurance coverage, it is not an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(a) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(b) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

NEW SECTION. **Sec. 7.** (1) Notwithstanding any other provisions of this title, no person may act or represent itself as a travel administrator for travel insurance in this state unless that person is licensed as an insurance producer with the travel limited line of authority.

(2) A travel administrator and its employees are exempt from the licensing requirements of RCW 48.17.060(2) for travel insurance it administers.

(3) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer, and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the commissioner upon request.

NEW SECTION. **Sec. 8.** (1)(a) Subject to (b) and (c) of this subsection, notwithstanding any other provision of this title, travel insurance is classified and filed for purposes of rates and forms under an inland marine line of insurance.

(b) Travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively, or in conjunction with related coverages of emergency evacuation or repatriation of remains, or incidental limited property and casualty benefits such as baggage or trip cancellation, may be filed under either an accident and health line of insurance or an inland marine line of insurance.

(c) The rates and forms filings per product may only be filed under one line of insurance.

(2) Travel insurance may be in the form of an individual, group, or blanket policy.

(3)(a) Travel insurance rates may vary due to marketing or distribution channels.

(b) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided those standards also meet the state's underwriting standards for inland marine.

(4) Subsections (1) through (3) of this section do not constitute a violation of RCW 48.18.480 when used for travel insurance.

NEW SECTION. **Sec. 9.** The commissioner may adopt rules as necessary to implement and administer this chapter and shall repeal existing rules pertaining to travel insurance that are inconsistent with this chapter.

NEW SECTION. **Sec. 10.** This chapter may be known and cited as the Washington travel insurance act.

NEW SECTION. **Sec. 11.** Sections 1 through 10 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.30 RCW to read as follows:

In accordance with section 6 of this act, it is an unfair trade practice to:

(1) Offer or sell a travel insurance policy that could never result in payment of any claims for any insured under the policy; or

(2) Market blanket travel insurance coverage as free.

Sec. 13. RCW 48.17.060 and 2010 c 67 s 3 are each amended to read as follows:

(1) A person shall not sell, solicit, or negotiate insurance in this state for any line or lines of insurance unless the person is licensed for that line of authority in accordance with this chapter.

(2)(a) A person may not act as or hold himself or herself out to be an adjuster in this state unless licensed by the commissioner or otherwise authorized to act as an adjuster under this chapter.

(b) In accordance with section 7(2) of this act, a travel administrator, as defined in section 2 of this act, and its employees are exempt from the licensing requirements of this subsection (2) for travel insurance it administers.

(3) A person may not act as or hold himself or herself out to be a crop adjuster in this state unless licensed by the commissioner or otherwise authorized to act as a crop adjuster under this chapter.

Sec. 14. RCW 48.43.005 and 2024 c 218 s 1 are each amended to read as follows:

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

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

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Air ambulance service" has the same meaning as defined in section 2799A-2 of the public health service act (42 U.S.C. Sec. 300gg-112) and implementing federal regulations in effect on March 31, 2022.

(4) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item

rendered by a participating provider or facility or by a nonparticipating provider or facility.

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

(6) "Balance bill" means a bill sent to an enrollee by a nonparticipating provider or facility for health care services provided to the enrollee after the provider or facility's billed amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

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

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

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

(10) "Behavioral health emergency services provider" means emergency services provided in the following settings:

(a) A crisis stabilization unit as defined in RCW 71.05.020;

(b) A 23-hour crisis relief center as defined in RCW 71.24.025;

(c) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(d) An agency certified by the department of health under chapter 71.24 RCW to provide outpatient crisis services;

(e) An agency certified by the department of health under chapter 71.24 RCW to provide medically managed or medically monitored withdrawal management services; or

(f) A mobile rapid response crisis team as defined in RCW 71.24.025 that is contracted with a behavioral health administrative services organization operating under RCW 71.24.045 to provide crisis response services in the behavioral health administrative services organization's service area.

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

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

(i) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, $1,750 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least $3,500, both amounts to be adjusted annually by the insurance commissioner; and

(ii) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, $3,500 and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least $6,000, both amounts to be adjusted annually by the insurance commissioner.

(b) In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding 12 months, as determined by the United States department of labor. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

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

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

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

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

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

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

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

(17) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(18) "Emergency services" means:

(a)(i) A medical screening examination, as required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition;

(ii) Medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered services provided by staff or facilities of a hospital after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to medical, mental health, or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect

to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or

(b)(i) A screening examination that is within the capability of a behavioral health emergency services provider including ancillary services routinely available to the behavioral health emergency services provider to evaluate that emergency medical condition;

(ii) Examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the behavioral health emergency services provider, as are required under section 1867 of the social security act (42 U.S.C. Sec. 1395dd) or as would be required under such section if such section applied to behavioral health emergency services providers, to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. Sec. 1395dd(e)(3)); and

(iii) Covered behavioral health services provided by staff or facilities of a behavioral health emergency services provider after the enrollee is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and stabilization services have been furnished. Poststabilization services relate to mental health or substance use disorder treatment necessary in the short term to avoid placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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

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

(21) "Essential health benefit categories" means:

(a) Ambulatory patient services;

(b) Emergency services;

(c) Hospitalization;

(d) Maternity and newborn care;

(e) Mental health and substance use disorder services, including behavioral health treatment;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and chronic disease management; and

(j) Pediatric services, including oral and vision care.

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

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

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

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

(26) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(27) "Ground ambulance services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose; and

(b) Ground ambulance transport between hospitals or behavioral health emergency services providers, hospitals or behavioral health

emergency services providers and other health care facilities or locations, and between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose.

(28) "Ground ambulance services organization" means a public or private organization licensed by the department of health under chapter 18.73 RCW to provide ground ambulance services. For purposes of this chapter, ground ambulance services organizations are not considered providers.

(29) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, ((~~psychiatric~~)) behavioral health hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 or 70.230 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(30) "Health care provider" or "provider" means:

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

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

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

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

(33) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide,

arrange, reimburse, or pay for health care services except the following:

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage;

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

(m) Civilian health and medical program for the veterans affairs administration (CHAMPVA); ((~~and~~))

(n) Stand-alone prescription drug coverage that exclusively supplements medicare part D coverage provided through an employer group waiver plan under federal social security act regulation 42 C.F.R. Sec. 423.458(c)<u>; and</u>

<u>(o) Beginning January 1, 2027, travel insurance as defined in section 2 of this act</u>.

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

(35) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations.

(36) "Local governmental entity" means any entity that is authorized to establish or provide ground ambulance services or set rates for ground ambulance services, including those as authorized in RCW 35.27.370, 35.23.456, 52.12.135, chapter 35.21 RCW, or as authorized under any state law.

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

(38) "Nonemergency health care services performed by nonparticipating providers at certain participating facilities" means covered items or services other than emergency services with respect to a visit at a participating health care facility, as provided in section 2799A-1(b) of the public health service act (42 U.S.C. Sec. 300gg-111(b)), 45 C.F.R. Sec. 149.30, and 45 C.F.R. Sec. 149.120 as in effect on March 31, 2022.

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

(40) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(41) "Out-of-pocket maximum" or "maximum out-of-pocket" means the maximum amount an enrollee is required to pay in the form of cost-sharing for covered benefits in a plan year, after which the carrier covers the entirety of the allowed amount of covered benefits under the contract of coverage.

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

(43) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the

continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(44)(a) "Protected individual" means:

(i) An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or

(ii) A minor who may obtain health care without the consent of a parent or legal guardian, pursuant to state or federal law.

(b) "Protected individual" does not include an individual deemed not competent to provide informed consent for care under RCW 11.88.010(1)(e).

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

(46) "Sensitive health care services" means health services related to reproductive health, sexually transmitted diseases, substance use disorder, gender dysphoria, gender-affirming care, domestic violence, and mental health.

(47) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than 50 employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer

meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least 75 percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least 51 percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

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

(49) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

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

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

NEW SECTION. **Sec. 15.** Sections 1 through 13 of this act take effect January 1, 2027.

--- END ---