Chapter 48.46 RCW
HEALTH MAINTENANCE ORGANIZATIONS

Sections

Insurance producers appointed by health maintenance organizations, additional regulations applicable: RCW 48.17.065.

RCW 48.46.010 Legislative declaration—Purpose. In affirmation of the declared principle that health care is a right of every citizen of the state, the legislature expresses its concern that the present high costs of health care in Washington may be preventing or inhibiting a large segment of the people from obtaining access to quality health care services.

The legislature declares that the establishment of qualified prepaid group and individual practice health care delivery systems should be encouraged in order to provide all citizens of the state with the freedom of choice between competitive, alternative health

care delivery systems necessary to realize their right to health. It is the purpose and policy of this chapter to provide for the development and registration of prepaid group and individual practice health care plans as health maintenance organizations, which the legislature declares to be in the interest of the health, safety and welfare of the people. [1975 1st ex.s. c 290 § 2.]

RCW 48.46.012 Filings with secretary of state—Copy for commissioner. Health maintenance organizations shall send a copy specifically for the office of the insurance commissioner to the secretary of state of any corporate document required to be filed in the office of the secretary of state, including articles of incorporation and bylaws, and any amendments thereto. The copy specifically provided for the office of the insurance commissioner shall be in addition to the copies required by the secretary of state and shall clearly indicate on the copy that it is for delivery to the office of the insurance commissioner. [1998 c 23 § 17.]

RCW 48.46.020 Definitions. As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual agreement.

(2) "Census date" means the date upon which a health maintenance organization offering coverage to a small employer must base rate calculations. For a small employer applying for a health benefit plan through a health maintenance organization other than its current health maintenance organization, the census date is the date that final group composition is received by the health maintenance organization. For a small employer that is renewing its health benefit plan through its existing health maintenance organization, the census date is ninety days prior to the effective date of the renewal.

(3) "Commissioner" means the insurance commissioner.

(4) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(5) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or shareholders of stock corporations licensed as health maintenance organizations.

(6) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(7) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(8) "Department" means the state department of social and health services.

(9) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(10) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.46.235(3) and are recorded as equity.

(11) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

(12) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(13) "Health maintenance organization" means any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(14) "Health professionals" means health care practitioners who are regulated by the state of Washington.

(15) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

(16) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(17) "Meaningful appeal procedure" and "meaningful adverse determination review procedure" means a procedure for investigation of consumer appeals and adverse review determinations in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures.

(18) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(19) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(20) "Participating provider" means a provider as defined in subsection (21) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(21) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

(22) "Replacement coverage" means the benefits provided by a succeeding carrier.

(23) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization. [2012 c 211 § 22. Prior: 2010 c 292 § 5; 1990 c 119 § 1; 1983 c 106 § 1; 1982 c 151 § 1; 1975 1st ex.s. c 290 § 3.]

Application—2010 c 292: See note following RCW 48.43.005.

Effective date—1982 c 151: "This act shall take effect on January 1, 1983." [1982 c 151 § 5.]

RCW 48.46.023 Insurance producer—Definition—License required—Application, issuance, renewal, fees—Penalties involving license. (1) Insurance producer, as used in this chapter, means any person appointed or authorized by a health maintenance organization to solicit applications for health care service agreements on its behalf.

(2) No person shall act as or hold himself or herself out to be an appointed insurance producer of a health maintenance organization unless licensed as a disability insurance producer by this state and appointed or authorized by the health maintenance organization on whose behalf solicitations are to be made.

(3) Applications, appointments, and qualifications for licenses, the renewal thereof, the fees and issuance of a license, and the renewal thereof shall be in accordance with the provisions of chapter 48.17 RCW that are applicable to a disability insurance producer.

(4) The commissioner may revoke, suspend, or refuse to issue or renew any insurance producer's license, or levy a fine upon the licensee, in accordance with those provisions of chapter 48.17 RCW that are applicable to a disability insurance producer. [2008 c 217 § 54; 1983 c 202 § 8.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.46.027 Registration, required—Issuance of securities—Penalty. (1) A person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health maintenance organization as defined in RCW 48.46.020 without first being registered with the commissioner.

(2) The issuance, sale, or offer for sale in this state of securities of its own issue by any health maintenance organization domiciled in this state other than the memberships and bonds of a nonprofit corporation is subject to the provisions of chapter 48.06 RCW relating to obtaining solicitation permits the same as if health maintenance organizations were domestic insurers.

(3) Any person violating any provision of subsection (2) of this section is guilty of a gross misdemeanor and will, upon conviction, be fined not more than one thousand dollars, or imprisoned for not more than six months, or both, for each violation. [2003 c 250 § 10; 1983 c 202 § 9.]

Severability—2003 c 250: See note following RCW 48.01.080.

RCW 48.46.030 Eligibility requirements for certificate of registration—Application requirements, information—Provider compensation. Any corporation, cooperative group, partnership, individual, association, or groups of health professionals licensed by the state of Washington, public hospital district, or public institutions of higher education shall be entitled to a certificate of registration from the insurance commissioner as a health maintenance organization if it:

(1) Provides comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provides such health services either directly or through arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health; and

(2) Is governed by a board elected by enrolled participants, or otherwise provides its enrolled participants with a meaningful role in policy making procedures of such organization, as defined in RCW 48.46.020(18) and 48.46.070; and

(3) Affords enrolled participants with a meaningful appeal procedure aimed at settlement of disputes between such persons and such health maintenance organization, as defined in RCW 48.46.020(17) and 48.46.100; and

(4) Provides enrolled participants, or makes available for inspection at least annually, financial statements pertaining to health maintenance agreements, disclosing income and expenses, assets and liabilities, and the bases for proposed rate adjustments for health maintenance agreements relating to its activity as a health maintenance organization; and

(5) Demonstrates to the satisfaction of the commissioner that its facilities and personnel are reasonably adequate to provide comprehensive health care services to enrolled participants and that it is financially capable of providing such members with, or has made adequate contractual arrangements through insurance or otherwise to provide such members with, such health services; and

(6) Substantially complies with administrative rules and regulations of the commissioner for purposes of this chapter; and

(7) Submits an application for a certificate of registration which shall be verified by an officer or authorized representative of the applicant, being in form as the commissioner prescribes, and setting forth:

(a) A copy of the basic organizational document, if any, of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar documents, if any, which regulate the conduct of the internal affairs of the applicant, and all amendments thereto;

(c) A list of the names, addresses, members of the board of directors, board of trustees, executive committee, or other governing board or committee and the principal officers, partners, or members;

(d) A full and complete disclosure of any financial interests held by any officer, or director in any provider associated with the applicant or any provider of the applicant;

(e) A description of the health maintenance organization, its facilities and its personnel, and the applicant's most recent financial statement showing such organization's assets, liabilities, income, and other sources of financial support;

(f) A description of the geographic areas and the population groups to be served and the size and composition of the anticipated enrollee population;

(g) A copy of each type of health maintenance agreement to be issued to enrolled participants;

(h) A schedule of all proposed rates of reimbursement to contracting health care facilities or providers, if any, and a schedule of the proposed charges for enrollee coverage for health care services, accompanied by data relevant to the formulation of such schedules;

(i) A description of the proposed method and schedule for soliciting enrollment in the applicant health maintenance organization and the basis of compensation for such solicitation services;

(j) A copy of the solicitation document to be distributed to all prospective enrolled participants in connection with any solicitation;

(k) A financial projection which sets forth the anticipated results during the initial two years of operation of such organization, accompanied by a summary of the assumptions and relevant data upon which the projection is based. The projection should include the projected expenses, enrollment trends, income, enrollee utilization patterns, and sources of working capital;

(l) A detailed description of the procedures and programs to be implemented to assure that the health care services delivered to enrolled participants will be of professional quality;

(m) A detailed description of procedures to be implemented to meet the requirements to protect against insolvency in RCW 48.46.245;

(n) Documentation that the health maintenance organization has an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under RCW 48.46.235; and

(o) Such other information as the commissioner shall require by rule or regulation which is reasonably necessary to carry out the provisions of this section.

A health maintenance organization shall, unless otherwise provided for in this chapter, file a notice describing any

modification of any of the information required by subsection (7) of this section. Such notice shall be filed with the commissioner. With respect to provider compensation; however, such notice shall be filed in compliance with the requirements regarding provider compensation filing in chapter 48.43 RCW. [2013 c 277 § 4; 2012 c 211 § 23; 1990 c 119 § 2; 1985 c 320 § 1; 1983 c 106 § 2; 1975 1st ex.s. c 290 § 4.]

RCW 48.46.033 Unregistered activities—Acts committed in this state—Sanctions. (1) As used in this section, "person" has the same meaning as in RCW 48.01.070.

(2) For the purpose of this section, an act is committed in this state if it is committed, in whole or in part, in the state of Washington, or affects persons or property within the state and relates to or involves a health maintenance agreement.

(3) Any person who knowingly violates RCW 48.46.027(1) is guilty of a class B felony punishable under chapter 9A.20 RCW.

(4) Any criminal penalty imposed under this section is in addition to, and not in lieu of, any other civil or administrative penalty or sanction otherwise authorized under state law.

(5)(a) If the commissioner has cause to believe that any person has violated the provisions of RCW 48.46.027(1), the commissioner may:

(i) Issue and enforce a cease and desist order in accordance with the provisions of RCW 48.02.080; and/or

(ii) Assess a civil penalty of not more than twenty-five thousand dollars for each violation, after providing notice and an opportunity for a hearing in accordance with chapters 34.05 and 48.04 RCW.

(b) Upon failure to pay a civil penalty when due, the attorney general may bring a civil action on behalf of the commissioner to recover the unpaid penalty. Any amounts collected by the commissioner must be paid to the state treasurer for the account of the general fund. [2003 c 250 § 11.]

Severability—2003 c 250: See note following RCW 48.01.080.

RCW 48.46.040 Certificate of registration—Issuance—Grounds for refusal—Name restrictions—Inspection and review of facilities. The commissioner shall issue a certificate of registration to the applicant within sixty days of such filing unless he or she notifies the applicant within such time that such application is not complete and the reasons therefor; or that he or she is not satisfied that:

(1) The basic organizational document of the applicant permits the applicant to conduct business as a health maintenance organization;

(2) The organization has demonstrated the intent and ability to assure that comprehensive health care services will be provided in a manner to assure both their availability and accessibility;

(3) The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination, the commissioner shall consider among other relevant factors:

(a) Any agreements with an insurer, a medical or hospital service bureau, a government agency or any other organization paying or insuring payment for health care services;

(b) Any arrangements for liability and malpractice insurance coverage; and

(c) Adequate procedures to be implemented to meet the protection against insolvency requirements in RCW 48.46.245;

(4) The procedures for offering health care services and offering or terminating contracts with enrolled participants are reasonable and equitable in comparison with prevailing health insurance subscription practices and health maintenance organization enrollment procedures; and, that

(5) Procedures have been established to:

(a) Monitor the quality of care provided by such organization, including, as a minimum, procedures for internal peer review;

(b) Offer enrolled participants an opportunity to participate in matters of policy and operation in accordance with RCW 48.46.020(18) and 48.46.070.

No person to whom a certificate of registration has not been issued, except a health maintenance organization certified by the secretary of the department of health and human services, pursuant to Public Law 93-222 or its successor, shall use the words "health maintenance organization" or the initials "HMO" in its name, contracts, or literature. Persons who are contracting with, operating in association with, recruiting enrolled participants for, or otherwise authorized by a health maintenance organization possessing a certificate of registration to act on its behalf may use the terms "health maintenance organization" or "HMO" for the limited purpose of denoting or explaining their relationship to such health maintenance organization.

The department of health, at the request of the insurance commissioner, shall inspect and review the facilities of every applicant health maintenance organization to determine that such facilities are reasonably adequate to provide the health care services offered in their contracts. If the commissioner has information to indicate that such facilities fail to continue to be adequate to provide the health care services offered, the department of health, upon request of the insurance commissioner, shall reinspect and review the facilities and report to the insurance commissioner as to their adequacy or inadequacy. [2012 c 211 § 24; 2009 c 549 § 7150; 1990 c 119 § 3; 1989 1st ex.s. c 9 § 223; 1983 c 106 § 3; 1975 1st ex.s. c 290 § 5.]

Effective date—Severability—1989 1st ex.s. c 9: See RCW 43.70.910 and 43.70.920.

RCW 48.46.045 Catastrophic health plans permitted. Notwithstanding the provisions of this chapter, a health maintenance organization may offer catastrophic health plans as defined in RCW 48.43.005. [2000 c 79 § 27.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.46.060 Prepayment agreements—Standards for forms and documents—Grounds for disapproval—Cancellation or failure to renew—Filing of agreement forms. (1) Any health maintenance organization

may enter into agreements with or for the benefit of persons or groups of persons, which require prepayment for health care services by or for such persons in consideration of the health maintenance organization providing health care services to such persons. Such activity is not subject to the laws relating to insurance if the health care services are rendered directly by the health maintenance organization or by any provider which has a contract or other arrangement with the health maintenance organization to render health services to enrolled participants.

(2) All forms of health maintenance agreements issued by the organization to enrolled participants or other marketing documents purporting to describe the organization's comprehensive health care services shall comply with such minimum standards as the commissioner deems reasonable and necessary in order to carry out the purposes and provisions of this chapter, and which fully inform enrolled participants of the health care services to which they are entitled, including any limitations or exclusions thereof, and such other rights, responsibilities and duties required of the contracting health maintenance organization.

(3) Subject to the right of the health maintenance organization to demand and receive a hearing under chapters 48.04 and 34.05 RCW, the commissioner may disapprove an individual or group agreement form for any of the following grounds:

(a) If it contains or incorporates by reference any inconsistent, ambiguous, or misleading clauses, or exceptions or conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the agreement;

(b) If it has any title, heading, or other indication which is misleading;

(c) If purchase of health care services thereunder is being solicited by deceptive advertising;

(d) If it contains unreasonable restrictions on the treatment of patients;

(e) If it is in any respect in violation of this chapter or if it fails to conform to minimum provisions or standards required by the commissioner by rule under chapter 34.05 RCW; or

(f) If any agreement for health care services with any state agency, division, subdivision, board, or commission or with any political subdivision, municipal corporation, or quasi-municipal corporation fails to comply with state law.

(4) In addition to the grounds listed in subsection (2) of this section, the commissioner may disapprove any agreement if the benefits provided therein are unreasonable in relation to the amount charged for the agreement. Rates, or any modification of rates effective on or after July 1, 2008, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner. If the commissioner does not disapprove a rate filing within sixty days after the health maintenance organization has filed the documents required in RCW 48.46.062(2) and any rules adopted pursuant thereto, the filing shall be deemed approved.

(5) No health maintenance organization authorized under this chapter shall cancel or fail to renew the enrollment on any basis of an enrolled participant or refuse to transfer an enrolled participant from a group to an individual basis for reasons relating solely to age, sex, race, or health status. Nothing contained herein shall prevent cancellation of an agreement with enrolled participants (a) who violate any published policies of the organization which have been

approved by the commissioner, or (b) who are entitled to become eligible for medicare benefits and fail to enroll for a medicare supplement plan offered by the health maintenance organization and approved by the commissioner, or (c) for failure of such enrolled participant to pay the approved charge, including cost-sharing, required under such contract, or (d) for a material breach of the health maintenance agreement.

(6) No agreement form or amendment to an approved agreement form shall be used unless it is first filed with the commissioner. [2008 c 303 § 3; 2000 c 79 § 31; 1989 c 10 § 10. Prior: 1985 c 320 § 2; 1985 c 283 § 2; 1983 c 106 § 4; 1975 1st ex.s. c 290 § 7.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.46.062 Schedule of rates for individual agreements—Loss ratio—Definitions. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Claims" means the cost to the health maintenance organization of health care services, as defined in RCW 48.43.005, provided to an enrollee or paid to or on behalf of the enrollee in accordance with the terms of a health benefit plan, as defined in RCW 48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for an enrollee.

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

(c) "Declination rate" for a health maintenance organization means the percentage of the total number of applicants for individual health benefit plans received by that health maintenance organization in the aggregate in the applicable year which are not accepted for enrollment by that health maintenance organization based on the results of the standard health questionnaire administered pursuant to *RCW 48.43.018(2)(a).

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

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

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

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

(2) A health maintenance organization must file supporting documentation of its method of determining the rates charged for its individual agreements. At a minimum, the health maintenance organization must provide the following supporting documentation:

(a) A description of the health maintenance organization's rate-making methodology;

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

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

(d) A certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard of seventy-four percent, minus the premium tax rate applicable to the carrier's individual health benefit plans under RCW 48.14.0201. [2011 c 314 § 12; 2008 c 303 § 6; 2001 c 196 § 12; 2000 c 79 § 32.]

***Reviser's note:** RCW 48.43.018 was repealed by 2019 c 33 § 7.

Effective date—2011 c 314 §§ 10-12: See note following RCW 48.20.025.

Effective date—2001 c 196: See note following RCW 48.20.025.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

RCW 48.46.063 Calculation of premiums—Members of a purchasing pool—Adjusted community rating method—Definitions. (1) Premiums for health benefit plans for individuals who purchase the plan as a member of a purchasing pool:

(a) Consisting of five hundred or more individuals affiliated with a particular industry;

(b) To whom care management services are provided as a benefit of pool membership; and

(c) Which allows contributions from more than one employer to be used towards the purchase of an individual's health benefit plan; shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. Such rates are subject to the following provisions:

(i) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(A) Geographic area;

(B) Family size;

(C) Age;

(D) Tenure discounts; and

(E) Wellness activities.

(ii) The adjustment for age in (c)(i)(C) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(iii) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer, and coverage for which medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(iv) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(v) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(vi) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(A) Changes to the family composition;

(B) Changes to the health benefit plan requested by the individual; or

(C) Changes in government requirements affecting the health benefit plan.

(vii) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(viii) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rates," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 6.]

***Reviser's note:** RCW 48.43.015 was repealed by 2019 c 33 § 7.

Legality of purchasing pools—Federal opinion requested—2006 c 100: See note following RCW 48.20.028.

RCW 48.46.064 Calculation of premiums—Adjusted community rate—Definitions. (1) Except for health benefit plans covered under RCW 48.46.063, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for

which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under **RCW 48.46.063, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rate," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005. [2006 c 100 § 5; 2004 c 244 § 8; 2000 c 79 § 33; 1997 c 231 § 209; 1995 c 265 § 17.]

Reviser's note: *(1) RCW 48.43.015 was repealed by 2019 c 33 § 7.

**(2) The reference in 2006 c 100 § 5 to "section 5 of this act" was erroneous. Section 6 of this act, codified as RCW 48.46.063, was apparently intended.

Legality of purchasing pools—Federal opinion requested—2006 c 100: See note following RCW 48.20.028.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.

Short title—Part headings and captions not law—Severability—Effective dates—1997 c 231: See notes following RCW 48.43.005.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.46.066 Health plan benefits for small employers—Coverage—Exemption from statutory requirements—Premium rates—Requirements for providing coverage for small employers. (1)(a) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

(2) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may,

after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) On the census date, as defined in RCW 48.46.020, rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, and differences in census date between new and renewal groups, with the exception of discounts for health improvement programs.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in *RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in **RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(j) For health benefit plans purchased through the health insurance partnership established in **chapter 70.47A RCW:

(i) Any surcharge established pursuant to **RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(k) If the rate developed under this section varies the adjusted community rate for the factors listed in (a) of this subsection, the date for determining those factors must be no more than ninety days prior to the effective date of the health benefit plan.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection and subsection (3)(g) of this section, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under **RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan. [2010 c 292 § 6; 2009 c 131 § 3; 2008 c 143 § 8; 2007 c 260 § 9; 2004 c 244 § 9; 1995 c 265 § 18; 1990 c 187 § 4.]

Reviser's note: *(1) RCW 48.43.015 was repealed by 2019 c 33 § 7.

**(2) Chapter 70.47A RCW was repealed in its entirety by 2017 3rd sp.s. c 25 § 9.

Application—2010 c 292: See note following RCW 48.43.005.

Application—2004 c 244: See note following RCW 48.21.045.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

Finding—Intent—Severability—1990 c 187: See notes following RCW 48.21.045.

RCW 48.46.068 Requirements for plans offered to small employers—Definitions. (1) A health maintenance organization may not offer any health benefit plan to any small employer without complying with RCW 48.46.066(3).

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

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005. [2003 c 248 § 16; 1995 c 265 § 24.]

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 48.46.070 Governing body. (1) The members of the governing body of a health maintenance organization shall be nominated by the voting members or by the enrolled participants and providers, and shall be elected by the enrolled participants or voting members pursuant to the provisions of their bylaws, which shall not be restricted to providers. At least one-third of such body shall consist of consumers who are substantially representative of the enrolled population of such organization: PROVIDED, HOWEVER, That any organization that is a qualified health maintenance organization under P.L. 93-222 (Title XIII, section 1310(d) of the public health services [service] act) is deemed to have satisfied these governing body requirements and the requirements of RCW 48.46.030(2).

(2) For health maintenance organizations formed by public institutions of higher education or public hospital districts, the governing body shall be advised by an advisory board consisting of at least two-thirds consumers who are elected by the voting members or the enrolled participants and are substantially representative of the enrolled population. [1985 c 320 § 3; 1983 c 106 § 5; 1975 1st ex.s. c 290 § 8.]

RCW 48.46.080 Annual statement—Filings—Contents—Fee—Penalty for failure to file—Accuracy required. (1) Every domestic health maintenance organization shall annually, on or before the first day of March, file with the commissioner a statement verified by at least two of the principal officers of the health maintenance organization showing its financial condition as of the last day of the preceding calendar year.

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

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

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

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

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

(b) The number of participants enrolled and terminated during the report period. Every employer offering health care benefits to their employees through a group contract with a health maintenance organization shall furnish said health maintenance organization with a list of their employees enrolled under such plan;

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

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

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

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

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

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

(5) Coincident with the filing of its annual statement and other schedules, each health maintenance organization shall pay a reasonable fee directly to the national association of insurance commissioners in

an amount approved by the commissioner to cover the costs associated with the analysis of the annual statement.

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

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

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

(9) No person shall knowingly file with any public official or knowingly make, publish, or disseminate any financial statement of a health maintenance organization which does not accurately state the health maintenance organization's financial condition. [2006 c 25 § 9; 1997 c 212 § 5; 1993 c 492 § 296. Prior: 1983 c 202 § 10; 1983 c 106 § 6; 1975 1st ex.s. c 290 § 9.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 48.46.090 Standard of services provided. A health maintenance organization, and the health care facilities and providers with which such organization has entered into contracts to provide health care services to its enrolled participants, shall provide such services in a manner consistent with the dignity of each enrolled participant as a human being. [1975 1st ex.s. c 290 § 10.]

RCW 48.46.100 Grievance procedure. A health maintenance organization shall establish and maintain a grievance procedure, approved by the commissioner, to provide reasonable and effective resolution of complaints initiated by enrolled participants concerning any matter relating to the interpretation of any provision of such enrolled participants' health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations, or nonrenewals of enrolled participants' coverage; and the quality of the health care services rendered, and which may include procedures for arbitration. [1975 1st ex.s. c 290 § 11.]

RCW 48.46.110 Name restrictions—Discrimination—Recovery of costs of health care services participant not entitled to. (1) No

health maintenance organization may refer to itself in its name or advertising with any of the words: "insurance", "casualty", "surety", "mutual", or any other words descriptive of the insurance, casualty, or surety business, or deceptively similar to the name or description of any insurance or surety corporation or health care service contractor or other health maintenance organization doing business in this state.

(2) No health maintenance organization, nor any health care facility or provider with which such organization has contracted to provide health care services, shall discriminate against any person from whom or on whose behalf, payment to meet the required charge is available, with regard to enrollment, disenrollment, or the provision of health care services, on the basis of such person's race, color, sex, religion, place of residence if there is reasonable access to the facility of the health maintenance organization, socioeconomic status, or status as a recipient of medicare under Title XVIII of the Social Security Act, 42 U.S.C. section 1396, et seq.

(3) Where a health maintenance organization determines that an enrolled participant has received health care services to which such enrolled participant is not entitled under the terms of his or her health maintenance agreement, neither such organization, nor any health care facility or provider with which such organization has contracted to provide health care services, shall have recourse against such enrolled participant for any amount above the actual cost of providing such service, if any, specified in such agreement, unless the enrolled participant or a member of his or her family has given or withheld information to the health maintenance organization, the effect of which is to mislead or misinform the health maintenance organization as to the enrolled participant's right to receive such services. [2009 c 549 § 7151; 1983 c 202 § 11; 1975 1st ex.s. c 290 § 12.]

RCW 48.46.120 Examination of health maintenance organizations—Duties of organizations, powers of commissioner—Independent audit reports. (1) The commissioner may make an examination of the operations of any health maintenance organization as often as he or she deems necessary in order to carry out the purposes of this chapter.

(2) Every health maintenance organization shall submit its books and records relating its operation for financial condition and market conduct examinations and in every way facilitate them. The quality or appropriateness of medical services or systems shall not be examined except to the extent that such items are incidental to an examination of the financial condition or the market conduct of a health maintenance organization. For the purpose of examinations, the commissioner may issue subpoenas, administer oaths, and examine the officers and principals of the health maintenance organization and the principals of such providers concerning their business.

(3) The commissioner may elect to accept and rely on audit reports made by an independent certified public accountant for the health maintenance organization in the course of that part of the commissioner's examination covering the same general subject matter as the audit. The commissioner may incorporate the audit report in his or her report of the examination. [2009 c 549 § 7152; 2007 c 468 § 2;

1987 c 83 § 1; 1986 c 296 § 9; 1985 c 7 § 115; 1983 c 63 § 2; 1975 1st ex.s. c 290 § 13.]

Severability—Effective date—1986 c 296: See notes following RCW 48.14.020.

RCW 48.46.130 Investigation of violations—Hearing—Findings—Penalties—Order requiring compliance, etc.—Suspension or revocation of certificate, effect—Application to courts. (1) The commissioner may, consistent with the provisions of the administrative procedure act, chapter 34.05 RCW, initiate proceedings to determine whether a health maintenance organization has:

(a) Operated in a manner that materially violates its organizational documents;

(b) Materially breached its obligation to furnish the health care services specified in its contracts with enrolled participants;

(c) Violated any provision of this chapter, or any rules and regulations promulgated thereunder;

(d) Made any false statement with respect to any report or statement required by this chapter or by the commissioner under this chapter;

(e) Advertised or marketed, or attempted to market, its services in such a manner as to misrepresent its services or capacity for services, or engaged in deceptive, misleading, or unfair practices with respect to advertising or marketing;

(f) Prevented the commissioner from the performance of any duty imposed by this chapter; or

(g) Fraudulently procured or attempted to procure any benefit under this chapter.

(2) After providing written notice and an opportunity for a hearing to be scheduled no sooner than ten days following such notice, the commissioner shall make administrative findings and may, as appropriate:

(a) Impose a penalty of not more than ten thousand dollars for each and every unlawful act committed which materially affects the health services offered or furnished;

(b) Issue an administrative order requiring the health maintenance organization to:

(i) Cease or modify inappropriate conduct or practices by it or any of the personnel employed or associated with it;

(ii) Fulfill its contractual obligations;

(iii) Provide a service which has been improperly denied;

(iv) Take steps to provide or arrange for any service which it has agreed to make available; or

(v) Abide by the terms of an arbitration proceeding, if any;

(c) Suspend or revoke the certificate of authority of the health maintenance organization:

(i) If its certificate of authority is suspended, the organization shall not, during the period of such suspension, enroll any additional participants except newborn children or other newly acquired dependents of existing enrolled participants, and shall not engage in any advertising or solicitation whatsoever;

(ii) If its certificate of authority is revoked, the organization shall proceed under the supervision of the commissioner immediately following the effective date of the order of revocation to wind up its

affairs, and shall conduct no further business except as may be essential to the orderly conclusion of such affairs: PROVIDED, That the commissioner may, by written order, permit such further operation of the organization as it may find to be in the best interest of enrolled participants, to the end that such enrolled participants will be afforded the greatest practical opportunity to obtain continuing health care coverage: PROVIDED, FURTHER, That if the organization is qualified to operate as a health care service contractor under chapter 48.44 RCW, it may continue to operate as such when it obtains the appropriate license.

(3) The commissioner may apply to any court for such legal or equitable relief as it deems necessary to effectively carry out the purposes of this chapter, including, but not limited to, an action in any court of competent jurisdiction to enjoin any such acts or practices and to enforce compliance with this chapter or any rule or order hereunder. Upon a proper showing a permanent or temporary injunction, restraining order, or writ of mandamus shall be granted and a receiver or conservator may be appointed for the defendant or the defendant's assets. The commissioner may not be required to post a bond. [1975 1st ex.s. c 290 § 14.]

RCW 48.46.135 Fine in addition to or in lieu of suspension, revocation, or refusal. After hearing or upon stipulation by the registrant and in addition to or in lieu of the suspension, revocation, or refusal to renew any registration of a health maintenance organization, the commissioner may levy a fine against the party involved for each offense in an amount not less than fifty dollars and not more than ten thousand dollars. The order levying such fine shall specify the period within which the fine shall be fully paid and which period shall not be less than fifteen nor more than thirty days from the date of such order. Upon failure to pay any such fine when due the commissioner shall revoke the registration of the registrant, if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the commissioner by the attorney general. Any fine so collected shall be paid by the commissioner to the state treasurer for the account of the general fund. [1983 c 202 § 15.]

RCW 48.46.140 Fees. Every organization subject to this chapter shall pay to the commissioner the following fees:

(1) For filing a copy of its application for a certificate of registration or amendment thereto, one hundred dollars;

(2) For filing each annual report pursuant to RCW 48.46.080, ten dollars. [1975 1st ex.s. c 290 § 15.]

RCW 48.46.170 Effect of chapter as to other laws—Construction. (1) Solicitation of enrolled participants by a health maintenance organization granted a certificate of registration, or its appointed insurance producers or representatives, does not violate any provision of law relating to solicitation or advertising by health professionals.

(2) Any health maintenance organization authorized under this chapter is not violating any law prohibiting the practice by

unlicensed persons of podiatric medicine and surgery, chiropractic, dental hygiene, opticianry, dentistry, optometry, osteopathic medicine and surgery, pharmacy, medicine and surgery, physical therapy, nursing, or psychology. This subsection does not expand a health professional's scope of practice or allow employees of a health maintenance organization to practice as a health professional unless licensed.

(3) This chapter does not alter any statutory obligation, or rule adopted thereunder, in chapter 70.38 RCW.

(4) Any health maintenance organization receiving a certificate of registration pursuant to this chapter is exempt from chapter 48.05 RCW. [2008 c 217 § 55; 2003 c 248 § 17; 1996 c 178 § 13; 1983 c 106 § 7; 1975 1st ex.s. c 290 § 18.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

Effective date—1996 c 178: See note following RCW 18.35.110.

RCW 48.46.180 Duty of employer to inform and make available to employees option of enrolling in health maintenance organization. (1) The state government, or any political subdivision thereof, which offers its employees a health benefits plan shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which such employees or members reside.

(2) Each employer, public or private, having more than fifty employees in this state which offers its employees a health benefits plan, and each employee benefits fund in this state having more than fifty members which offers its members any form of health benefits shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which a substantial number of such employees or members reside: PROVIDED, That unless at least twenty-five employees agree to participate in a health maintenance organization the employer need not provide such an option: PROVIDED FURTHER, That where such employees are members of a bona fide bargaining unit covered by a labor-management collective bargaining agreement, the selection of the options required by this section may be specified in such agreement: AND PROVIDED FURTHER, That the provisions of this section shall not be mandatory where such members are covered by a Taft-Hartley health care trust, except that the labor-management trustees may contract with a health maintenance organization if a feasibility study determines it is to the advantage of the members to so contract.

(3) Subsections (1) and (2) of this section shall impose no responsibilities or duties upon state government or any political subdivision thereof or any other employer, either public or private, to provide health maintenance organization coverage when no health maintenance organization exists for the purpose of providing health care services in the geographic areas in which the employees or members reside.

(4) No employer in this state shall in any way be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract of obligation for the provision of health benefits between such employer and its employees. [1975 1st ex.s. c 290 § 19.]

RCW 48.46.190 Payroll deductions for capitation payments to health maintenance organizations. See RCW 41.04.233.

RCW 48.46.200 Rules and regulations. The commissioner may, in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW, promulgate rules and regulations as necessary or proper to carry out the provisions of this chapter. Nothing in this chapter shall be construed to prohibit the commissioner from requiring changes in procedures previously approved by him or her. [2009 c 549 § 7153; 1975 1st ex.s. c 290 § 21.]

RCW 48.46.210 Compliance with federal funding requirements—Construction. Nothing in this chapter shall prohibit any health maintenance organization from meeting the requirements of any federal law which would authorize such health maintenance organization to receive federal financial assistance or enroll beneficiaries assisted by federal funds. [1975 1st ex.s. c 290 § 22.]

RCW 48.46.220 Review of administrative action. Any party aggrieved by a decision, order, or regulation made under this chapter by the commissioner shall have the right to have such reviewed pursuant to the provisions of the administrative procedure act, chapter 34.05 RCW. [1975 1st ex.s. c 290 § 23.]

RCW 48.46.225 Financial failure—Supervision of commissioner—Priority of distribution of assets. (1) Any rehabilitation, liquidation, or conservation of a health maintenance organization is the same as the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in RCW 48.31.030, 48.31.050, and 48.31.080. Enrolled participants have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

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

maintenance agreement, that liability has the status of an enrolled participant claim for distribution of general assets.

(3) A provider who is obligated by statute or agreement to hold enrolled participants harmless from liability for services provided pursuant to and covered by a health care plan has a priority of distribution of the general assets immediately following that of enrolled participants and enrolled participants' beneficiaries under this section. [2003 c 248 § 18; 1990 c 119 § 4.]

RCW 48.46.235 Minimum net worth—Requirement to maintain—Determination of amount. (1) Except as provided in subsection (2) of this section, every health maintenance organization must have and maintain a minimum net worth equal to the greater of:

(a) Three million dollars; or

(b) Two percent of annual premium earned as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars; or

(c) An amount equal to the sum of three months' uncovered expenditures as reported on the most recent financial statement filed with the commissioner.

(2) A health maintenance organization registered before July 27, 1997, that, on July 27, 1997, has a minimum net worth equal to or greater than that required by subsection (1) of this section must continue to have and maintain the minimum net worth required by subsection (1) of this section. A health maintenance organization registered before July 27, 1997, that, on July 27, 1997, does not have the minimum net worth required by subsection (1) of this section must have and maintain a minimum net worth of:

(a) The amount required immediately prior to July 27, 1997, until December 31, 1997;

(b) Fifty percent of the amount required by subsection (1) of this section by December 31, 1997;

(c) Seventy-five percent of the amount required by subsection (1) of this section by December 31, 1998; and

(d) One hundred percent of the amount required by subsection (1) of this section by December 31, 1999.

(3)(a) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. An interest obligation relating to the repayment of a subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of a fully subordinated debt shall not be considered uncovered expenditures.

(c) A subordinated debt incurred by a note meeting the requirement of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(4) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures that have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims.

Such liabilities shall be computed in accordance with rules promulgated by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization. [1997 c 212 § 6; 1990 c 119 § 5.]

RCW 48.46.237 Minimum net worth—Domestic or foreign health maintenance organization. (1) For purposes of this section:

(a) "Domestic health maintenance organization" means a health maintenance organization formed under the laws of this state; and

(b) "Foreign health maintenance organization" means a health maintenance organization formed under the laws of the United States, of a state or territory of the United States other than this state, or of the District of Columbia.

(2) If the minimum net worth of a domestic health maintenance organization falls below the minimum net worth required by this chapter, the commissioner shall at once ascertain the amount of the deficiency and serve notice upon the domestic health maintenance organization to cure the deficiency within ninety days after that service of notice.

(3) If the deficiency is not cured, and proof thereof filed with the commissioner within the ninety-day period, the domestic health maintenance organization shall be declared insolvent and shall be proceeded against as authorized by this code or the commissioner shall, consistent with chapters 48.04 and 34.05 RCW, suspend or revoke the registration of the domestic health maintenance organization as being hazardous to its subscribers and the people in this state.

(4) If the deficiency is not cured the domestic health maintenance organization shall not issue or deliver any health maintenance agreement after the expiration of the ninety-day period.

(5) If the minimum net worth of a foreign health maintenance organization falls below the minimum net worth required by this chapter, the commissioner shall, consistent with chapters 48.04 and 34.05 RCW, suspend or revoke the foreign health maintenance organization's registration as being hazardous to its subscribers, enrollees, or the people in this state. [1997 c 212 § 7.]

RCW 48.46.240 Funded reserve requirements. (1) Each health maintenance organization obtaining a certificate of registration from the commissioner shall provide and maintain a funded reserve of one hundred fifty thousand dollars. The funded reserve shall be deposited with the commissioner or with any organization/trustee acceptable to him or her in the form of cash, securities eligible for investment by the health maintenance organization pursuant to chapter 48.13 RCW, approved surety bond or any combination of these, and must equal or exceed one hundred fifty thousand dollars. The funded reserve shall be established as an assurance that the uncovered expenditure obligations of the health maintenance organization to the enrolled participants will be performed.

(2) All income from reserves on deposit with the commissioner shall belong to the depositing health maintenance organization and shall be paid to it as it becomes available.

(3) Any funded reserve required by this section shall be considered an asset of the health maintenance organization in determining the organization's net worth.

(4) A health maintenance organization that has made a securities deposit with the commissioner may, at its option, withdraw the securities deposit or any part of the deposit after first having deposited or provided in lieu thereof an approved surety bond, a deposit of cash or securities, or any combination of these or other deposits of equal amount and value to that withdrawn. Any securities and surety bond shall be subject to approval by the commissioner before being substituted. [2009 c 549 § 7154; 1990 c 119 § 6; 1985 c 320 § 4; 1982 c 151 § 3.]

Effective date—1982 c 151: See note following RCW 48.46.020.

RCW 48.46.243 Contract—Participant liability. (1) Subject to subsection (2) of this section, every contract between a health maintenance organization and its participating providers of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the agreement, the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization. Every such contract shall provide that this requirement shall survive termination of the contract.

(2) The provisions of subsection (1) of this section shall not apply:

(a) To emergency care from a provider who is not a participating provider;

(b) To out-of-area services;

(c) To the delivery of covered pediatric oral services that are substantially equal to the essential health benefits benchmark plan; or

(d) In exceptional situations approved in advance by the commissioner, if the health maintenance organization is unable to negotiate reasonable and cost-effective participating provider contracts.

(3) No participating provider, or insurance producer, trustee, or assignee thereof, may maintain an action against an enrolled participant to collect sums owed by the health maintenance organization. [2016 c 122 § 3. Prior: 2013 c 325 § 2; 2013 c 277 § 3; 2008 c 217 § 56; 1990 c 119 § 7.]

Intent—2016 c 122: "It is the intent of the legislature to allow certain provider compensation exhibits to remain confidential by making permanent the provisions of chapter 277, Laws of 2013, which currently expire July 1, 2017, thereby maintaining efficient review and approval of health care plans by the insurance commissioner and fostering innovation in the Washington health insurance market." [2016 c 122 § 1.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.46.245 Plan for handling insolvency—Commissioner's review. Each health maintenance organization shall have a plan for handling insolvency which allows for continuation of benefits for the duration of the agreement period for which premiums have been paid and

continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The commissioner shall approve such a plan if it includes:

(1) Insurance to cover the expenses to be paid for continued benefits after insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrolled participants' discharge from inpatient facilities;

(3) Use of insolvency reserves established under RCW 48.46.240;

(4) Acceptable letters of credit or approved surety bonds; or

(5) Any other arrangements the commissioner and the organization mutually agree are appropriate to assure that benefits are continued. [1990 c 119 § 8.]

RCW 48.46.247 Insolvency—Commissioner's duties—Participants' options—Allocation of coverage. (1)(a) In the event of insolvency of a health care service contractor or health maintenance organization and upon order of the commissioner, all other carriers then having active enrolled participants under a group plan with the affected agreement holder that participated in the enrollment process with the insolvent health care service contractor or health maintenance organization at a group's last regular enrollment period shall offer the eligible enrolled participants of the insolvent health services contractor or health maintenance organization the opportunity to enroll in an existing group plan without medical underwriting during a thirty-day open enrollment period, commencing on the date of the insolvency. Eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's group plan. An open enrollment shall not be required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule, unless the plan administrator and agreement holder voluntarily agree to offer a simultaneous open enrollment and extend coverage under the same enrollment terms and conditions as are applicable to carriers under this title and rules adopted under this title. If an exempt plan was offered during the last regular open enrollment period, then the carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this title for the duration of the current agreement period.

(b) For purposes of this subsection only, the term "carrier" means a health maintenance organization or a health care service contractor. In the event of insolvency of a carrier and if no other carrier has active enrolled participants under a group plan with the affected agreement holder, or if the commissioner determines that the other carriers lack sufficient health care delivery resources to assure that health services will be available or accessible to all of the group enrollees of the insolvent carrier, then the commissioner shall allocate equitably the insolvent carrier's group agreements for these groups among all carriers that operate within a portion of the insolvent carrier's area, taking into consideration the health care

delivery resources of each carrier. Each carrier to which a group or groups are allocated shall offer the agreement holder, without medical underwriting, the carrier's existing coverage that is most similar to each group's coverage with the insolvent carrier at rates determined in accordance with the successor carrier's existing rating methodology. The eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's group plan. No offering by a carrier shall be required where the agreement holder participates in a self-insured, self-funded, or other health plan exempt from commissioner rule. The carrier may offer the agreement holder the same coverage as any self-insured plan or plans offered by the agreement holder without regard to coverage, benefit, or provider requirements mandated by this title for the duration of the current agreement period.

(2) The commissioner shall also allocate equitably the insolvent carrier's nongroup enrolled participants who are unable to obtain coverage among all carriers that operate within a portion of the insolvent carrier's service area, taking into consideration the health care delivery resources of the carrier. Each carrier to which nongroup enrolled participants are allocated shall offer the nongroup enrolled participants the carrier's existing comprehensive conversion plan, without additional medical underwriting, at rates determined in accordance with the successor carrier's existing rating methodology. The eligible enrolled participants shall not be subject to preexisting condition limitations except to the extent that a waiting period for a preexisting condition has not been satisfied under the insolvent carrier's plan.

(3) Any agreements covering participants allocated pursuant to subsections (1)(b) and (2) of this section to carriers pursuant to this section may be rerated after ninety days of coverage.

(4) A limited health care service contractor shall not be required to offer services other than its one limited health care service to any enrolled participant of an insolvent carrier. [1990 c 119 § 9.]

RCW 48.46.250 Coverage of dependent children—Newborn infants, congenital anomalies—Notification period. (1) Any health maintenance agreement under this chapter which provides coverage for dependent children of the enrolled participant shall provide the same coverage for newborn infants of the enrolled participant from and after the moment of birth. Coverage provided under this section shall include, but not be limited to, coverage for congenital anomalies of such children from the moment of birth.

(2) If payment of an additional premium is required to provide coverage for a child, the agreement may require that notification of birth of a newly born child and payment of the required premiums must be furnished to the health maintenance organization. The notification period shall be no less than sixty days from the date of birth. This subsection applies to agreements issued or renewed on or after January 1, 1984. [1984 c 4 § 2; 1983 c 202 § 12.]

RCW 48.46.260 Individual health maintenance agreement—Return within ten days of delivery—Refunds—Void from beginning. Every

subscriber of an individual health maintenance agreement may return the agreement to the health maintenance organization or the insurance producer through whom it was purchased within ten days of its delivery to the subscriber if, after examination of the agreement, the subscriber is not satisfied with it for any reason. The health maintenance organization shall refund promptly any fee paid for the agreement. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy to the health maintenance organization or insurance producer. Upon such return of the agreement, it shall be void from the beginning and the parties shall be in the same position as if no agreement had been issued. Notice of the provisions of this section shall be printed on the face of each such agreement or be attached thereto. [2008 c 217 § 57; 1983 c 202 § 13.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.46.270 Financial interests of health maintenance organization authorities, restricted—Exceptions, regulations. (1) No person having any authority in the investment or disposition of the funds of a health maintenance organization and no officer or director of a health maintenance organization shall accept, except for the health maintenance organization, or be the beneficiary of any fee, brokerage, gift, commission, or other emolument because of any sale of health care service agreements or any investment, loan, deposit, purchase, sale, payment, or exchange made by or for the health maintenance organization, or be pecuniarily interested therein in any capacity; except, that such a person may procure a loan from the health maintenance organization directly upon approval by two-thirds of its directors and upon the pledge of securities eligible for the investment of the health maintenance organization's funds under this title.

(2) The commissioner may, by regulations, from time to time, define and permit additional exceptions to the prohibition contained in subsection (1) of this section solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the health maintenance organization, or to a corporation or firm in which the director is interested, for necessary services performed or sales or purchases made to or for the health maintenance organization in the ordinary course of the health maintenance organization's business and in the usual private professional or business capacity of the director or the corporation or firm. [1985 c 320 § 5; 1983 c 202 § 14.]

RCW 48.46.272 Diabetes coverage—Definitions. The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

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

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All health benefit plans offered by health maintenance organizations, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all health benefit plans, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health maintenance organization from restricting patients to seeing only health care providers who have signed participating provider agreements with the health maintenance organization or an insuring entity under contract with the health maintenance organization.

(3) Except as provided in RCW 48.43.780, coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

(6) The health maintenance organization need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.

(7) This section does not apply to the health benefit plans that provide benefits identical to the schedule of services covered by the basic health plan. [2020 c 346 § 10; 2020 c 245 § 6; 2004 c 244 § 14; 1997 c 276 § 5.]

Reviser's note: This section was amended by 2020 c 245 § 6 and by 2020 c 346 § 10, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Intent—2020 c 346: See note following RCW 70.14.165.

Application—2004 c 244: See note following RCW 48.21.045.

Effective date—1997 c 276: See note following RCW 41.05.185.

RCW 48.46.274 Prescribed, self-administered anticancer medication. (1) Each health plan issued or renewed on or after January 1, 2012, that provides coverage for cancer chemotherapy treatment must provide coverage for prescribed, self-administered anticancer medication that is used to kill or slow the growth of cancerous cells on a basis at least comparable to cancer chemotherapy medications administered by a health care provider or facility as defined in *RCW 48.43.005 (25) and (26).

(2) Nothing in this section may be interpreted to prohibit a health plan from administering a formulary or preferred drug list, requiring prior authorization, or imposing other appropriate utilization controls in approving coverage for any chemotherapy. [2020 c 18 § 22; 2011 c 159 § 6.]

***Reviser's note:** RCW 48.43.005 was alphabetized pursuant to RCW 1.08.015(2)(k), changing subsections (25) and (26) to subsections (27) and (28).

Explanatory statement—2020 c 18: See note following RCW 43.79A.040.

Findings—2011 c 159: See note following RCW 41.05.175.

RCW 48.46.275 Mammograms—Insurance coverage. Each health maintenance agreement issued or renewed after January 1, 1990, that provides benefits for hospital or medical care shall provide benefits for screening or diagnostic mammography services, provided that such services are delivered upon the recommendation of the patient's physician or advanced registered nurse practitioner as authorized by the *nursing care quality assurance commission pursuant to chapter 18.79 RCW or physician assistant pursuant to chapter 18.71A RCW.

All services must be provided by the health maintenance organization or rendered upon referral by the health maintenance organization. This section shall not be construed to prevent the application of standard agreement provisions, other than the cost-sharing prohibition provided in RCW 48.43.076, that are applicable to other benefits. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of mammography services. This section shall not apply to medicare supplement policies or supplemental contracts covering a specified disease or other limited benefits. [2023 c 366 § 6; 1994 sp.s. c 9 § 735; 1989 c 338 § 4.]

***Reviser's note:** The reference to "nursing care quality assurance commission" was changed to "board of nursing" by 2023 c 123.

Intent—2023 c 366: See note following RCW 48.43.076.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 48.46.277 Prostate cancer screening. (1) Each health maintenance agreement issued or renewed after December 31, 2006, that provides coverage for hospital or medical expenses shall provide coverage for prostate cancer screening, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

(2) All services must be provided by the health maintenance organization or rendered upon a referral by the health maintenance organization.

(3) This section shall not be construed to prevent the application of standard policy provisions applicable to other benefits, such as deductible or copayment provisions. This section does not limit the authority of a health maintenance organization to negotiate rates and contract with specific providers for the delivery of prostate cancer screening services. This section shall not apply to medicare supplemental policies or supplemental contracts covering a specified disease or other limited benefits. [2006 c 367 § 5.]

RCW 48.46.280 Reconstructive breast surgery. (1) Any health care service plan issued, amended, or renewed after July 24, 1983, shall provide coverage for reconstructive breast surgery resulting from a mastectomy which resulted from disease, illness, or injury.

(2) Any health care service plan issued, amended, or renewed after January 1, 1986, shall provide coverage for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. [1985 c 54 § 8; 1983 c 113 § 4.]

Effective date—1985 c 54: See note following RCW 48.20.397.

RCW 48.46.285 Mastectomy, lumpectomy. No health maintenance organization under this chapter may refuse coverage or cancel or decline coverage solely because of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. The amount of benefits payable, or any term, rate, condition, or type of coverage shall not be restricted, modified, excluded, increased, or reduced solely on the basis of a mastectomy or lumpectomy performed on the insured or prospective insured more than five years previously. [1985 c 54 § 4.]

Effective date—1985 c 54: See note following RCW 48.20.397.

RCW 48.46.291 Mental health services—Health plans—Definition—Coverage required, when. (1) For the purposes of this section, "mental health services" means:

(a) For health benefit plans issued or renewed before January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the

purposes of chapter 6, Laws of 2005, with the exception of the following categories, codes, and services: (i) Substance related disorders; (ii) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American psychiatric association; (iii) skilled nursing facility services, home health care, residential treatment, and custodial care; and (iv) court ordered treatment unless the health maintenance organization's medical director or designee determines the treatment to be medically necessary; and

(b) For a health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, issued or renewed on or after January 1, 2021, medically necessary outpatient and inpatient services provided to treat mental health and substance use disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, on June 11, 2020, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005.

(2) A health benefit plan or a plan deemed by the commissioner to have a short-term limited purpose or duration, offered by health maintenance organizations that provide coverage for medical and surgical services shall provide coverage for:

(a) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison. If the health benefit plan imposes a maximum out-of-pocket limit or stop loss, it shall be a single limit or stop loss for medical, surgical, and mental health services. If the health benefit plan imposes any deductible, mental health services shall be included with medical and surgical services for the purpose of meeting the deductible requirement. Treatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services; and

(b) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

(3) This section does not prohibit a requirement that mental health services be medically necessary, if a comparable requirement is applicable to medical and surgical services.

(4) Nothing in this section shall be construed to prevent the management of mental health services if a comparable requirement is applicable to medical and surgical services. [2020 c 228 § 6; 2007 c 8 § 4; 2006 c 74 § 3; 2005 c 6 § 5.]

Effective date—2007 c 8: See note following RCW 48.20.580.

Effective date—2006 c 74: See note following RCW 48.21.241.

Findings—Intent—Severability—2005 c 6: See notes following RCW 41.05.600.

RCW 48.46.292 Mental health treatment—Waiver of preauthorization for persons involuntarily committed. A health maintenance organization providing services or benefits for hospital or medical care coverage in this state shall waive a preauthorization from the health maintenance organization before an enrolled participant or the enrolled participant's covered dependents receive mental health treatment rendered by a state hospital as defined in RCW 72.23.010 if the enrolled participant or the enrolled participant's covered dependents are involuntarily committed to a state hospital as defined in RCW 72.23.010. [1993 c 272 § 5.]

Savings—Severability—1993 c 272: See notes following RCW 43.20B.347.

RCW 48.46.300 Future dividends or refunds, restricted—Issuance or sale of securities regulated. (1) No health maintenance organization nor any individual acting in behalf thereof may guarantee or agree to the payment of future dividends or future refunds of unused charges or savings in any specific or approximate amounts or percentages in respect to any contract being offered to the public, except in a group contract containing an experience refund provision.

(2) The issuance, sale, or offer for sale in this state of securities of its own issue by any health maintenance organization domiciled in this state other than the memberships and bonds of a nonprofit corporation are subject to the provisions of chapter 48.06 RCW relating to obtaining solicitation permits. [1983 c 106 § 8.]

RCW 48.46.310 Registration not endorsement. The granting of a certificate of registration to a health maintenance organization is permissive only, and does not constitute an endorsement by the insurance commissioner of any person or thing related to the health maintenance organization, and no person may advertise or display a certificate of registration for use as an inducement in any solicitation. [1983 c 106 § 9.]

RCW 48.46.320 Dependent children, termination of coverage, conditions. Any health maintenance agreement which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the agreement shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both: (1) Incapable of self-sustaining employment by reason of developmental or physical disability; and (2) chiefly dependent upon the subscriber for support and maintenance, if proof of such incapacity and dependency is furnished to the health maintenance organization by the enrolled participant within thirty-one days of the child's attainment of the limiting age and subsequently as required by the health maintenance organization but not more frequently than

annually after the two-year period following the child's attainment of the limiting age. [2020 c 274 § 38; 1985 c 320 § 6; 1983 c 106 § 10.]

RCW 48.46.325 Option to cover child under age twenty-six. (1) Each individual health maintenance agreement that is not grandfathered and that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six.

(2) Each group health maintenance agreement that is not grandfathered and that provides coverage for a participating member's child must offer each participating member the option of covering any child under the age of twenty-six.

(3) Each grandfathered individual or group health maintenance agreement that provides coverage for a subscriber's child must offer the option of covering any child under the age of twenty-six, unless that child is eligible to enroll in an eligible health plan sponsored by the child's employer or the child's spouse's employer.

(4) As used in this section, "grandfathered" has the same meaning as "grandfathered health plan" in RCW 48.43.005. [2012 c 211 § 19; 2011 c 314 § 8; 2007 c 259 § 22.]

Effective date—2007 c 259 §§ 18-22: See note following RCW 41.05.095.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 48.46.340 Return of agreement within ten days. Every subscriber of an individual health maintenance agreement may return the agreement to the health maintenance organization or the insurance producer through whom it was purchased within ten days of its delivery to the subscriber if, after examination of the agreement, the subscriber is not satisfied with it for any reason. The health maintenance organization shall refund promptly any fee paid for the agreement. Upon such return of the agreement, it shall be void from the beginning and the parties shall be in the same position as if no agreement had been issued. Notice of the substance of this section shall be printed on the face of each such agreement or be attached thereto. [2008 c 217 § 58; 1983 c 106 § 12.]

Severability—Effective date—2008 c 217: See notes following RCW 48.03.020.

RCW 48.46.350 Chemical dependency treatment. Each group agreement for health care services that is delivered or issued for delivery or renewed on or after January 1, 1988, must contain provisions providing benefits for the treatment of chemical dependency rendered to covered persons by a provider which is an "approved substance use disorder treatment program" under *RCW 70.96A.020(2). However, this section does not apply to any agreement written as supplemental coverage to any federal or state programs of health care including, but not limited to, Title XVIII health insurance for the aged, which is commonly referred to as Medicare, Parts A&B, and amendments thereto. Treatment must be covered under the chemical dependency coverage if treatment is rendered by the health maintenance

organization or if the health maintenance organization refers the enrolled participant or the enrolled participant's dependents to a physician licensed under chapter 18.57 or 18.71 RCW, or to a qualified counselor employed by an approved substance use disorder treatment program described in *RCW 70.96A.020(2). In all cases, a health maintenance organization retains the right to diagnose the presence of chemical dependency and select the modality of treatment that best serves the interest of the health maintenance organization's enrolled participant, or the enrolled participant's covered dependent. [2018 c 201 § 8013; 2003 c 248 § 19; 1990 1st ex.s. c 3 § 14; 1987 c 458 § 18; 1983 c 106 § 13.]

***Reviser's note:** RCW 70.96A.020 was repealed by 2016 sp.s. c 29 § 301.

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

Effective date—Severability—1987 c 458: See notes following RCW 48.21.160.

Chemical dependency benefits, rules: RCW 48.21.197.

RCW 48.46.355 "Chemical dependency" defined. For the purposes of RCW 48.46.350, "chemical dependency" means an illness characterized by a physiological of psychological dependency, or both, on a controlled substance regulated under chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. [1987 c 458 § 19.]

Effective date—Severability—1987 c 458: See notes following RCW 48.21.160.

RCW 48.46.360 Payment of cost of agreement directly to holder during labor dispute—Changes restricted—Notice to employee. Any employee whose compensation includes a health maintenance agreement, the cost of which is paid in full or in part by an employer including the state of Washington, its political subdivisions, or municipal corporations, or paid by payroll deduction, may pay the cost as it becomes due directly to the agreement holder whenever the employee's compensation is suspended or terminated directly or indirectly as a result of a strike, lockout, or other labor dispute, for a period not exceeding six months and at the rate and coverages as the health maintenance agreement provides. During that period of time, such agreement may not be altered or changed. Nothing in this section impairs the right of the health maintenance organization to make normal decreases or increases in the cost of the health maintenance agreement upon expiration and renewal of the agreement, in accordance with the agreement. Thereafter, if such health maintenance agreement

is no longer available, the employee shall be given the opportunity to convert as specified in RCW 48.46.450 and 48.46.460. When the employee's compensation is so suspended or terminated, the employee shall be notified immediately by the agreement holder in writing, by mail addressed to the address last of record with the agreement holder, that the employee may pay the cost of the health maintenance agreement to the agreement holder as it becomes due as provided in this section. Payment must be made when due or the coverage may be terminated by the health maintenance organization. [1985 c 7 § 116; 1983 c 106 § 14.]

RCW 48.46.370 Coverage not denied for disability. No health maintenance organization may deny coverage to a person solely on account of the presence of any disability. Nothing in this section may be construed as limiting a health maintenance organization's authority to deny or otherwise limit coverage to a person when the person because of a medical condition does not meet the essential eligibility requirements established by the health maintenance organization for purposes of determining coverage for any person. [2020 c 274 § 39; 1983 c 106 § 15.]

RCW 48.46.375 Benefits for prenatal diagnosis of congenital disorders—Agreements entered into or renewed on or after January 1, 1990. On or after January 1, 1990, every group health maintenance agreement entered into or renewed that covers hospital, medical, or surgical expenses and which provides benefits for pregnancy, childbirth, or related medical conditions to enrollees of such groups, shall offer benefits for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy to such enrollees when those services are determined to be medically necessary by the health maintenance organization in accord with standards set in rule by the board of health: PROVIDED, That such procedures shall be covered only if rendered directly by the health maintenance organization or upon referral by the health maintenance organization. Every group health maintenance organization shall communicate the availability of such coverage to all groups covered and to all groups with whom they are negotiating. [1988 c 276 § 8.]

Prenatal testing—Limitation on changes to coverage: RCW 48.42.090.

RCW 48.46.380 Notice of reason for cancellation, denial, or refusal to renew agreement. Every authorized health maintenance organization, upon canceling, denying, or refusing to renew any individual health maintenance agreement, shall, upon written request, directly notify in writing the applicant or enrolled participant as appropriate, of the reasons for the action by the health maintenance organization. Any benefits, terms, rates, or conditions of such agreement which are restricted, excluded, modified, increased, or reduced shall, upon written request, be set forth in writing and supplied to the individual. The written communications required by this section shall be phrased in simple language which is readily understandable to a person of average intelligence, education, and reading ability. [1993 c 492 § 291; 1983 c 106 § 16.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW 43.72.910 through 43.72.915.

RCW 48.46.390 Providing information on cancellation or refusal—No liability for insurance commissioner or health maintenance organization. With respect to the provisions of health maintenance agreements as set forth in RCW 48.46.380, there shall be no liability on the part of, and no cause of action of any nature shall arise against, the insurance commissioner, the commissioner's agents, or members of the commissioner's staff, or against any health maintenance organization, its authorized representative, its agents, its employees, for providing to the health maintenance organization information as to reasons for cancellation or refusal to issue or renew, for libel or slander on the basis of any statement made by any of them in any written notice of cancellation or refusal to issue or renew, or in any other communications, oral or written, specifying the reasons for cancellation or refusal to issue or renew or the providing of information pertaining thereto, or for statements made or evidence submitted in any hearing conducted in connection therewith. [1983 c 106 § 17.]

RCW 48.46.400 False or misleading advertising prohibited. No person may knowingly make, publish, or disseminate any false, deceptive, or misleading representation or advertising in the conduct of the business of a health maintenance organization, or relative to the business of a health maintenance organization or to any person engaged therein. [1983 c 106 § 18.]

RCW 48.46.410 Misrepresentations to induce termination or retention of agreement prohibited. No health maintenance organization nor any person representing a health maintenance organization may by misrepresentation or misleading comparisons induce or attempt to induce any member of a health maintenance organization to terminate or retain an agreement or membership in the organization. [1983 c 106 § 19.]

RCW 48.46.420 Penalty for violations. (1) Except as otherwise provided in this chapter, any health maintenance organization which, or person who, violates any provision of this chapter is guilty of a gross misdemeanor.

(2) A health maintenance organization that fails to comply with the net worth requirements of this chapter must cure that defect in compliance with an order of the commissioner rendered in conformity with rules adopted pursuant to chapter 34.05 RCW. The commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrolled participants. [2003 c 250 § 12; 1990 c 119 § 10; 1983 c 106 § 20.]

Severability—2003 c 250: See note following RCW 48.01.080.

RCW 48.46.430 Enforcement authority of commissioner. For the purposes of this chapter, the insurance commissioner shall have the same powers and duties of enforcement as are provided in RCW 48.02.080. [1983 c 106 § 21.]

RCW 48.46.440 Continuation option to be offered. Every health maintenance organization that issues agreements providing group coverage for hospital or medical care shall offer the agreement holder an option to include an agreement provision granting a person who becomes ineligible for coverage under the group agreement, the right to continue the group benefits for a period of time and at a rate agreed upon. The agreement provision shall provide that when such coverage terminates the covered person may convert to an agreement as provided in RCW 48.46.450. [1984 c 190 § 8.]

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

Application—1984 c 190 §§ 2, 5, and 8: See note following RCW 48.21.250.

RCW 48.46.450 Conversion agreement to be offered—Exceptions, conditions. (1) Except as otherwise provided by this section, any group health maintenance agreement that provides benefits for hospital or medical care must contain a provision granting a person covered by the group agreement the right to obtain a conversion agreement from the health maintenance organization upon termination of the person's eligibility for coverage under the group agreement.

(2) A health maintenance organization need not offer a conversion agreement to:

(a) A person whose coverage under the group agreement ended when the person's employment or membership was terminated for misconduct: PROVIDED, That when a person's employment or membership is terminated for misconduct, a conversion policy shall be offered to the spouse and/or dependents of the terminated employee or member. The policy shall include in the conversion provisions the same conversion rights and conditions which are available to employees or members and their spouses and/or dependents who are terminated for reasons other than misconduct;

(b) A person who is eligible for federal medicare coverage; or

(c) A person who is covered under another group plan, policy, contract, or agreement providing benefits for hospital or medical care.

(3) To obtain the conversion agreement, a person must submit a written application and the first premium payment for the conversion agreement not later than thirty-one days after the date the person's eligibility for group coverage terminates or thirty-one days after the date the person received notice of termination of coverage, whichever is later. The conversion agreement shall become effective without lapse of coverage, immediately following termination of coverage under the group agreement.

(4) If a health maintenance organization or group agreement holder does not renew, cancels, or otherwise terminates the group agreement, the health maintenance organization must offer a conversion

agreement to any person who was covered under the terminated agreement unless the person is eligible to obtain group benefits for hospital or medical care within thirty-one days after such nonrenewal, cancellation, or termination of the group agreement or thirty-one days after the date the person received notice of termination of coverage, whichever is later.

(5) The health maintenance organization shall determine the premium for the conversion agreement in accordance with the organization's table of premium rates applicable to the age and class of risk of each person to be covered under the agreement and the type and amount of benefits provided. [2010 c 110 § 3; 1984 c 190 § 9.]

Application—2010 c 110: See note following RCW 48.21.260.

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

RCW 48.46.460 Conversion agreement—Restrictions and requirements—Rules. (1) A health maintenance organization must offer a conversion agreement for comprehensive health care services and shall not require proof of insurability as a condition for issuance of the conversion agreement.

(2) A conversion agreement may not contain an exclusion for preexisting conditions for an applicant.

(3) A conversion agreement need not provide benefits identical to those provided under the group agreement. The conversion agreement may contain provisions requiring the person covered by the conversion agreement to pay reasonable deductibles and copayments, except for preventive service benefits as defined in 45 C.F.R. 147.130 (2010), implementing sections 2701 through 2763, 2791, and 2792 of the public health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

(4) The insurance commissioner shall adopt rules to establish minimum benefit standards for conversion agreements.

(5) The commissioner shall adopt rules to establish specific standards for conversion agreement provisions. These rules may include but are not limited to:

(a) Terms of renewability;

(b) Nonduplication of coverage;

(c) Benefit limitations, exceptions, and reductions; and

(d) Definitions of terms. [2019 c 33 § 6; 2011 c 314 § 9; 1984 c 190 § 10.]

Effective date—2019 c 33: See note following RCW 48.43.005.

Legislative intent—Severability—1984 c 190: See notes following RCW 48.21.250.

RCW 48.46.470 Endorsement of modifications. If an individual health care service agreement is issued on any basis other than as applied for, an endorsement setting forth such modification must accompany and be attached to the agreement. No agreement shall be effective unless the endorsement is signed by the applicant, and a

signed copy thereof returned to the health maintenance organization. [1985 c 320 § 7.]

RCW 48.46.480 Continuation of coverage of former family members. Every health care service agreement issued, amended, or renewed after January 1, 1986, for an individual and his or her dependents shall contain provisions to assure that the covered spouse and/or dependents, in the event that any cease to be a qualified family member by reason of termination of marriage or death of the principal enrollee, shall have the right to continue the health maintenance agreement without a physical examination, statement of health, or other proof of insurability. [1985 c 320 § 8.]

RCW 48.46.490 Coverage for adopted children. (1) Any health maintenance agreement under this chapter which provides coverage for dependent children, as defined in the agreement of the enrolled participant, shall cover adoptive children placed with the enrolled participant on the same basis as other dependents, as provided in RCW 48.01.180.

(2) If payment of an additional premium is required to provide coverage for a child, the agreement may require that notification of placement of a child for adoption and payment of the required premium must be furnished to the health maintenance organization. The notification period shall be no less than sixty days from the date of placement. [1986 c 140 § 5.]

Effective date, application—Severability—1986 c 140: See notes following RCW 48.01.180.

RCW 48.46.500 Cancellation of rider. Upon application by an enrollee, a rider shall be canceled if at least five years after its issuance, no health care services have been received by the enrollee during that time for the condition specified in the rider, and a physician, selected by the carrier for that purpose, agrees in writing to the full medical recovery of the enrollee from that condition, such agreement not to be unreasonably withheld. The option of the enrollee to apply for cancellation shall be disclosed on the face of the rider in clear and conspicuous language.

For purposes of this section, a rider is a legal document that modifies a contract to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. [1987 c 37 § 4.]

RCW 48.46.510 Phenylketonuria. (1) The legislature finds that:

(a) Phenylketonuria is a rare inherited genetic disorder.

(b) Children with phenylketonuria are unable to metabolize an essential amino acid, phenylalanine, which is found in the proteins of most food.

(c) To remain healthy, children with phenylketonuria must maintain a strict diet and ingest a mineral and vitamin-enriched formula.

(d) Children who do not maintain their diets with the formula acquire severe mental and physical difficulties.

(e) Originally, the formulas were listed as prescription drugs but were reclassified as medical foods to increase their availability.

(2) Subject to requirements and exceptions which may be established by rules adopted by the commissioner, any agreement for health care services delivered or issued for delivery or renewed in this state on or after September 1, 1988, shall provide coverage for the formulas necessary for the treatment of phenylketonuria. Such formulas shall be covered when deemed medically necessary by the medical director or his or her designee of the health maintenance organization and if provided by the health maintenance organization or upon the health maintenance organization's referral. Formulas shall be covered at the usual and customary rates for such formulas, subject to contract provisions with respect to deductible amounts or copayments. [1988 c 173 § 4.]

RCW 48.46.520 Neurodevelopmental therapies—Employer-sponsored group contracts. (1) Each employer-sponsored group contract for comprehensive health care service which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individuals age six and under.

(2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy, and physical therapy. Covered benefits and treatment must be rendered or referred by the health maintenance organization, and delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where treatment is rendered by such licensee. Nothing in this section shall prohibit a health maintenance organization from negotiating rates with qualified providers.

(3) Benefits provided under this section shall be for medically necessary services as determined by the health maintenance organization. Benefits shall be provided for the maintenance of a covered enrollee in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be provided to restore and improve function.

(4) It is the intent of this section that employers purchasing comprehensive group coverage including the benefits required by this section, together with the health maintenance organization, retain authority to design and employ utilization and cost controls. Therefore, benefits provided under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing coverage and the health maintenance organization. Benefits provided under this section may be subject to standard waiting periods for preexisting conditions, and may be subject to the submission of written treatment plans.

(5) In recognition of the intent expressed in subsection (4) of this section, benefits provided under this section may be subject to contractual provisions establishing annual and/or lifetime benefit limits. Such limits may define the total dollar benefits available, or may limit the number of services delivered as agreed by the employer purchasing coverage and the health maintenance organization. [1989 c 345 § 3.]

RCW 48.46.530 Temporomandibular joint disorders—Insurance coverage. (1) Except as provided in this section, a health maintenance agreement entered into or renewed after December 31, 1989, shall offer optional coverage for the treatment of temporomandibular joint disorders.

(a) Health maintenance organizations offering medical coverage only may limit benefits in such coverages to medical services related to treatment of temporomandibular joint disorders. No health maintenance organizations offering medical and dental coverage may limit benefits in such coverage to dental services related to treatment of temporomandibular joint disorders. No health maintenance organization offering medical coverage only may define all temporomandibular joint disorders as purely dental in nature.

(b) Health maintenance organizations offering optional temporomandibular joint disorder coverage as provided in this section may, but are not required to, offer lesser or no temporomandibular joint disorder coverage as part of their basic group disability contract.

(c) Benefits and coverage offered under this section may be subject to negotiation to promote broad flexibility in potential benefit coverage. This flexibility shall apply to services to be reimbursed, determination of treatments to be considered medically necessary, systems through which services are to be provided, including referral systems and use of other providers, and related issues.

(2) Unless otherwise directed by law, the insurance commissioner shall adopt rules, to be implemented on January 1, 1993, establishing minimum benefits, terms, definitions, conditions, limitations, and provisions for the use of reasonable deductibles and copayments.

(3) A health maintenance organization need not make the offer of coverage required by this section to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefit statutes under Title 48 RCW that does not provide coverage for temporomandibular joint disorders. [1989 c 331 § 4.]

Legislative finding—Effective date—1989 c 331: See notes following RCW 48.21.320.

RCW 48.46.535 Prescriptions—Preapproval of individual claims—Subsequent rejection prohibited—Written record required. Health maintenance organizations who through an authorized representative have first approved, by any means, an individual prescription claim as eligible may not reject that claim at some later date. Pharmacists or drug dispensing outlets who obtain preapproval of claims shall keep a written record of the preapproval that consists of identification by name and telephone number of the person who approved the claim. [1993 c 253 § 5.]

Findings—Effective date—1993 c 253: See notes following RCW 48.20.525.

RCW 48.46.540 Nonresident pharmacies. For the purposes of this chapter, a nonresident pharmacy is defined as any pharmacy located

outside this state that ships, mails, or delivers, in any manner, except when delivered in person to an enrolled participant or his/her representative, controlled substances, legend drugs, or devices into this state.

After October 1, 1991, a health maintenance organization providing coverage of prescription drugs from nonresident pharmacies may only provide coverage from licensed nonresident pharmacies. The health maintenance organizations shall obtain proof of current licensure in conformity with this section and RCW 18.64.350 through 18.64.400 from the nonresident pharmacy and keep that proof of licensure on file.

The department may request from the health maintenance organization the proof of current licensure for all nonresident pharmacies through which the insurer is providing coverage for prescription drugs for residents of the state of Washington. This information, which may constitute a full or partial customer list, shall be confidential and exempt from public disclosure, and from the requirements of chapter 42.56 RCW. The board or the department shall not be restricted in the disclosure of the name of a nonresident pharmacy that is or has been licensed under RCW 18.64.360 or 18.64.370 or of the identity of a nonresident pharmacy disciplined under RCW 18.64.350 through 18.64.400. [2005 c 274 § 315; 1991 c 87 § 10.]

Effective date—1991 c 87: See note following RCW 18.64.350.

RCW 48.46.565 Foot care services. Except to the extent that a health maintenance organization contracts with a group medical practice which only treats that organization's patients, a health maintenance organization may not discriminate in the terms and conditions, including reimbursement, for the provision of foot care services between physicians and surgeons licensed under chapters 18.22, 18.57, and 18.71 RCW. [1999 c 64 § 1.]

Intent—1999 c 64: "This act is intended to be procedural and not to impair the obligation of any existing contract." [1999 c 64 § 2.]

Severability—1999 c 64: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1999 c 64 § 3.]

RCW 48.46.570 Denturist services. Notwithstanding any provision of any health maintenance organization agreement covering dental care as provided for in this chapter, effective January 1, 1995, benefits shall not be denied thereunder for any service performed by a denturist licensed under chapter 18.30 RCW if (1) the service performed was within the lawful scope of such person's license, and (2) such agreement would have provided benefits if such service had been performed by a dentist licensed under chapter 18.32 RCW. [1995 c 1 § 25 (Initiative Measure No. 607, approved November 8, 1994).]

Short title—1995 c 1 (Initiative Measure No. 607): See RCW 18.30.900.

RCW 48.46.575 Doctor of osteopathic medicine and surgery—Discrimination based on board certification is prohibited. A health maintenance organization that provides health care services to the general public may not discriminate against a qualified doctor of osteopathic medicine and surgery licensed under chapter 18.57 RCW, who has applied to practice with the health maintenance organization, solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of board certified or eligible respectively under an approved medical certifying board. [1995 c 64 § 1.]

RCW 48.46.580 When injury caused by intoxication or use of narcotics. A health maintenance organization may not deny coverage for the treatment of an injury solely because the injury was sustained as a consequence of the enrolled participant's being intoxicated or under the influence of a narcotic. [2004 c 112 § 5.]

Finding—Application—2004 c 112: See notes following RCW 48.20.385.

RCW 48.46.600 Disclosure of certain material transactions—Report—Information is confidential. (1) Every health maintenance organization domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless these acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval, or information purposes under other provisions of this title or other requirements.

(2) The report required in subsection (1) of this section is due within fifteen days after the end of the calendar month in which any of the transactions occur.

(3) One complete copy of the report, including any exhibits or other attachments filed as part of the report, shall be filed with the:

(a) Commissioner; and

(b) National association of insurance commissioners.

(4) All reports obtained by or disclosed to the commissioner under this section and RCW 48.46.605 through 48.46.625 are exempt from public inspection and copying and shall not be subject to subpoena. These reports shall not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior written consent of the health maintenance organization to which it pertains unless the commissioner, after giving the health maintenance organization that would be affected by disclosure notice and a hearing under chapter 48.04 RCW, determines that the interest of policyholders, subscribers, shareholders, or the public will be served by the publication, in which event the commissioner may publish all or any part of the report in the manner he or she deems appropriate. [1995 c 86 § 19.]

RCW 48.46.605 Material acquisitions or dispositions. No acquisitions or dispositions of assets need be reported pursuant to RCW 48.46.600 if the acquisitions or dispositions are not material. For purposes of RCW 48.46.600 through 48.46.625, a material acquisition, or the aggregate of any series of related acquisitions during any thirty-day period; or disposition, or the aggregate of any series of related dispositions during any thirty-day period is an acquisition or disposition that is nonrecurring and not in the ordinary course of business and involves more than five percent of the reporting health maintenance organization's total assets as reported in its most recent statutory statement filed with the commissioner. [1995 c 86 § 20.]

RCW 48.46.610 Asset acquisitions—Asset dispositions. (1) Asset acquisitions subject to RCW 48.46.600 through 48.46.625 include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition other than the construction or development of real property by or for the reporting health maintenance organization or the acquisition of materials for such purpose.

(2) Asset dispositions subject to RCW 48.46.600 through 48.46.625 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, abandonment, destruction, other disposition, or assignment, whether for the benefit of creditors or otherwise. [1995 c 86 § 21.]

RCW 48.46.615 Report of a material acquisition or disposition of assets—Information required. The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(1) Date of the transaction;

(2) Manner of acquisition or disposition;

(3) Description of the assets involved;

(4) Nature and amount of the consideration given or received;

(5) Purpose of or reason for the transaction;

(6) Manner by which the amount of consideration was determined;

(7) Gain or loss recognized or realized as a result of the transaction; and

(8) Names of the persons from whom the assets were acquired or to whom they were disposed. [1995 c 86 § 22.]

RCW 48.46.620 Material nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) No nonrenewals, cancellations, or revisions of ceded reinsurance agreements need be reported under RCW 48.46.600 if the nonrenewals, cancellations, or revisions are not material. For purposes of RCW 48.46.600 through 48.46.625, a material nonrenewal, cancellation, or revision is one that affects:

(a) More than fifty percent of a health maintenance organization's total reserve credit taken for business ceded, on an annualized basis, as indicated in the health maintenance organization's most recent annual statement;

(b) More than ten percent of a health maintenance organization's total cession when it is replaced by one or more unauthorized reinsurers; or

(c) Previously established collateral requirements, when they have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent of a total cession.

(2) However, a filing is not required if a health maintenance organization's total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent of the statutory reserve requirement prior to any cession. [1995 c 86 § 23.]

RCW 48.46.625 Report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements—Information required. The following is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(1) The effective date of the nonrenewal, cancellation or revision;

(2) The description of the transaction with an identification of the initiator;

(3) The purpose of or reason for the transaction; and

(4) If applicable, the identity of the replacement reinsurers. [1995 c 86 § 24.]

RCW 48.46.900 Liberal construction. It is intended that the provisions of this chapter shall be liberally construed to accomplish the purposes provided for and authorized herein. [1975 1st ex.s. c 290 § 24.]

RCW 48.46.920 Short title. This 1975 amendatory act may be known and cited as "The Washington Health Maintenance Organization Act of 1975". [1975 1st ex.s. c 290 § 27.]

RCW 48.46.930 Construction—Chapter applicable to state registered domestic partnerships—2009 c 521. For the purposes of this chapter, the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin, and family shall be interpreted as applying equally to state registered domestic partnerships or individuals in state registered domestic partnerships as well as to marital relationships and married persons, and references to dissolution of marriage shall apply equally to state registered domestic partnerships that have been terminated, dissolved, or invalidated, to the extent that such interpretation does not conflict with federal law. Where necessary to implement chapter 521, Laws of 2009, gender-specific terms such as husband and wife used in any statute, rule, or other law shall be construed to be gender neutral, and applicable to individuals in state registered domestic partnerships. [2009 c 521 § 127.]