Table of Contents

I. WA State Disability Specific Laws

A. Marketing Methods and Practices

1. Outline of Coverage and Disclosure Forms… (284-50-410 through 440)

a) An Outline of Coverage is required to be given on all disability insurance policies ***at the time of application*** and acknowledgment of receipt is provided to the insurer. The **Outline of Coverage** form must include:

- ✓ A brief *specific* description of the benefits contained in *this policy.* **A description of policy provisions such as: renewability rights, age restrictions, and the right to change premiums, any deductibles or copayment requirements.**
- ✓ The Outline of Coverage form must state that the outline ***is not the insurance contract (policy) itself, and*** it makes clear that the insured needs to **read the policy carefully when received!**
- ✓ Disability income coverage, accident-only coverage, and specified disease and specified accident coverage policies **must** state that ***coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.***

b) Disclosure for Replacement Policies… (284-50-430): Applications must include a question asking whether the insurance to be issued is intended to replace any other disability insurance presently in force. An insurer must furnish the applicant**, prior to issuance or delivery of the policy**, a *Notice to Applicant Regarding Replacement.* One copy of such notice will be retained by the applicant and a copy signed by the applicant will be retained by the insurer.

- ✓ "Health conditions which you presently have may **not** be covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy."

c) Disclosure Form for Fixed Benefit Policies… (284-50-440): Any insurer offering individual **illness triggered fixed payment insurance, hospital confinement fixed payment insurance or other fixed payment insurance** must issue a disclosure form to all applicants at the time of solicitation and must state:

- ✓ **This coverage is not comprehensive health care insurance and will not cover the cost of most hospitals and other medical services**.
- ✓ This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. ***Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.***
- ✓ The benefits under this policy must be summarized and must include any policy provisions that exclude, eliminate, restrict, reduce, or limit payment of the benefits.

2. The Washington Medicare Supplement Health Insurance Act… (284-66-010, 020)

The **Purpose and Scope** of this chapter is to supplement the requirements of the Medicare Supplement Health Insurance Act and to assure the orderly implementation of changes in the federal Medicare program. This section applies to every individual and group insurance policy that is designed as a supplement for reimbursements that are made under Medicare.

Medicare Supplement (a.k.a. Medigap) policies are sold by ***insurance companies*** to pay for what Medicare approves but does not pay. In general, Medicare pays benefits for: hospitalization, physician services, hospice, outpatient prescription drugs (if you are enrolled in Medicare Part D), and other approved items and services.

Laws and Rules Pertaining to Medicare Supplement Policies:

- ***Applicants must be at least 65 years of age and covered under Part A and Part B of Medicare.***
- **A beneficiary may not have two Medigap policies at once.** Both state and federal laws prohibit insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

a) An exclusion for pre-existing conditions is allowed for a maximum of ***three months (90 days)***. A pre-existing condition is a condition for which medical advice was given or treatment was recommended within three months before the date of coverage. Note: ISO standards are 180 days. *Washington makes it safer for the consumer. Check if the question calls out Washington.*

284-66-170 No exclusions are permitted when ***replacing*** an in-force Medigap policy. Should an in-force policy be replaced, a replacement form is required to be filled out, signed, and the original left with the beneficiary.

b) Open enrollment (48.66.025) guarantees that for six months immediately following enrollment in **Part B**, persons aged 65 and older cannot be denied Medigap insurance.

c) A licensee or representative of an insurer or organization MAY NOT:

- ***Knowingly sell a Medigap contract to any person who is receiving or applying for Medicaid.***
- ***Complete the medical history portion of any form or application for the purchase of such a policy*** (the medical history questions must be completed by the applicant, applicant's spouse, legal guardian, or physician).

d) Policies must be guaranteed renewable All policies in Washington must be guaranteed renewable meaning the carrier may not cancel or non-renew for any reasons other than non-payment of premium or fraud. Premiums may increase but only on a classification basis, not individually.

e) Policies must have a 31-day grace period. All Medicare Supplement and Long-Term Care policies in Washington State must have a minimum 31-day grace period regardless of the mode of premium payment.

f) Return of Policy (48.66.120): Every Medicare supplement policy must display, on the first page of the policy, a notice stating that the insured will be permitted to return the policy or certificate ***within thirty days*** of its delivery to the purchaser and to have all the ***paid premium refunded if the purchaser is not satisfied with it for any reason***.

A *ten percent* charge will be added as a penalty to any premium refund due which is *not paid within thirty days* of return of the policy to the insurer or producer.

g) Guarantee Issue… (284-66-064 (4a, 4b)) Every issuer of a standardized Medicare supplement plan issued on or after June 1, 2010, must issue, *without evidence of insurability*, coverage under a 2010 plan to any policyholder if the Medicare supplement policy replaces another supplement plan issued prior to June 1, 2010.

- ∅ *(Note: Medigap plans D and G changed their benefits on June 1, 2010, E, H, I, and J are no longer sold, but, if someone purchased one of them they could generally keep it.)*
- ∅ *If someone with an old plan wants to switch to a new plan they can do so without proving they are insurable.*
- ∅ *If someone with a new pan wants to switch types, they may have to show insurability and could be turned down.*

h) Attained Age Rating Prohibited (284-66-310)… This law prohibits ***the increasing age of an insured*** as the basis for increasing premiums on a Medicare supplement policy. The rating practice commonly referred to as "attained age rating" is prohibited.

- A Medicare supplement policy **MAY NOT** use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions *(e.g., no permanent exclusions, impairment riders, rate-up, or surcharges).*

- A Medicare supplement policy **MAY NOT** be issued or renewed with benefits for outpatient prescription drugs. Prescription drugs are covered under Medicare Part D.

i) Appropriateness of recommended purchase and excessive insurance. (284-66-340)

(1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an insurance producer must make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of a Medicare supplement policy or certificate that will provide an individual with more than one Medicare supplement policy or certificate is prohibited.

(3) An issuer may not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

j) Standards for marketing. (284-66-340)

(1) Every issuer marketing Medicare supplement insurance coverage in this state, directly or through its producers, must:

(a) Establish marketing procedures to assure that any comparison of policies or certificates by its insurance producers will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

(c) Display prominently by type, stamp, or other appropriate means, on the first page of the policy or certificate the following:

"NOTICE TO BUYER: THIS (POLICY, CONTRACT, OR CERTIFICATE) MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has disability insurance and the types and amounts of any such insurance.

(e) Establish auditable procedures for verifying compliance with this section.

(2) In addition to the acts and practices prohibited in chapter 48.30 RCW, chapters 284-30 and 284-50 WAC, and this chapter, the commissioner has found and hereby defines the following to be unfair acts or practices and unfair methods of competition, and prohibited practices for any issuer, or their respective appointed insurance producers either directly or indirectly:

(a) Twisting. Making misrepresentations or misleading comparisons of any insurance policies or issuers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, keep, or convert any insurance policy.

(b) High-pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat whether explicit or implied, or otherwise applying undue pressure to coerce the purchase of, or recommend the purchase of, insurance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing that fails to disclose conspicuously that a purpose of the method of marketing is the solicitation of insurance and that contact will be made by an insurance producer or insurance company.

3. Medicare Supplement Outline of Coverage and Disclosure (284-66-080, 120, 135)

Issuers must provide an outline of coverage to all applicants **at the time of application** and must obtain an acknowledgment of receipt of the outline from the applicant.

- Any **disability or health insurance policy** (other than a Medicare Supplement policy) that provides coverage to a person who is eligible for Medicare must disclose to that person:

  - ✓ "This policy is not a Medicare supplement policy. If you are eligible for Medicare, review the ***Guide to Health Insurance for People with Medicare*** available from the company." The notice must be attached to the first page of the outline of coverage.

  - ✓ Both federal and state laws prohibit the sale of a health insurance policy that duplicates Medicare benefits unless it will pay benefits without regard to other disabilities or other health care coverage and it includes the prescribed disclosure statement on the application.

4. Buyer's guide (284-66-110)

- Issuers of disability insurance policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare must provide to all such applicants the pamphlet "Guide to Health Insurance for People with Medicare," developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services, (CMS), or any reproduction or official revision of that pamphlet.

- Delivery of the guide must be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement insurance policies or certificates.

- Except in the case of direct response issuers, delivery of the guide must be made to the applicant at the time of application, and acknowledgment of receipt of the guide must be obtained by the issuer.

5. The Long-Term Care Insurance Act… (48.83.020, .130; 284-17-262, 264)

"**Long-term care insurance**" means an insurance policy, contract, or rider that is designed to provide coverage for at **least twelve consecutive months**.

- ✓ Long-term care insurance may be on an expense incurred basis (pays only what the covered expenses to the insured are) or ***indemnity basis*** (set dollar amount to the insured regardless of what the expenses are), for medically necessary services or whichever comes first. *E.g., a policy may pay for 5 years or until a maximum of $150,000 has been paid out, whichever comes first.*

- ✓ Long-term care insurance includes any policy, contract, or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity

- ✓ Long-term care insurance includes group and individual annuities and life insurance policies or riders that provide long-term care insurance.

Long-term care insurance does not include any insurance policy, or rider that is offered primarily to provide coverage for basic Medicare supplement, basic hospital or basic surgical expense, major medical expense, disability income, accident only, specified disease, or limited benefit health.

A Long-Term Care "Policy" includes a document such as an insurance policy, rider or contract delivered or issued in this state by an insurer or any similar entity authorized by the Insurance Commissioner to transact the business of long-term care insurance.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements IRC7702b.

6. Education Requirement… (48.83.130, 284-17-262, 264)

A person may not sell, solicit, or negotiate long-term care insurance unless he or she is appropriately licensed as an insurance producer and has successfully completed long-term care coverage education that meets the requirements of this section.

Producers engaged in the transaction of long-term care insurance currently are required to take a ***specially approved eight-hour (8) LTC certification course.*** It is the insurer's responsibility to verify the completion of the course at any time to the insurance commissioner.

- This may not include any carrier product-specific training

- ✓ After the first course, a ***four-hour (4)*** *refresher course per renewal is required.*

- ✓ The approved LTC courses count towards the required twenty-four hours of continuing education for the renewal of licenses.

7. Health Care False Claims Act… (48.80.010, .020, .030)

It is recognized that fraudulent health care claims contribute to increases in health care costs. Special attention has been directed at eliminating false and fraudulent claims by establishing specific penalties and deterrents.

- ***No person may present a false or fraudulent claim*** under contract of insurance. This includes preparing false or fraudulent proof of loss with the intent that it be used in support of such a claim.

- No person may obtain a health care payment in an amount greater than that to which the person is entitled.

- ***A violation of this section is a*** **class C felony. Each claim that violates this section will constitute a separate violation.**

- This law does not apply to statements made on an application for coverage under an insurance contract or certificate of health care coverage.

B. (Washington) Health Insurance Reform Act… (48.43.005)

1. Definitions… (48.43.005)

(PLEASE NOTE: Students should be familiar with the following definitions but will not need to memorize them for the state exam.)

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

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

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

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

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

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

"Basic health plan services" means that schedule of covered health services.

"Board" means the governing board of the Washington health benefit exchange established by law.

"**Catastrophic health plan"** means, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars ($1750).

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

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

"Covered person" or **"enrollee"** means a person covered by a health plan.

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

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a *prudent layperson*, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

"Emergency services" means a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital.

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

"Enrollee point-of-service cost-sharing" may include co-payments, coinsurance, or deductibles.

"Exchange" means the Washington health benefit exchange.

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

"Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan at the completion of the internal appeals process.

"Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act and as amended by the Health Care and Education Reconciliation Act, is not subject to subtitles A or C of the Act as amended.

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

"Health care facility" or **"facility"** means hospices, hospitals, rural health care facilities, psychiatric hospitals, nursing homes, community mental health centers, kidney disease treatment centers, ambulatory diagnostic, treatment, or surgical facilities, drug and alcohol treatment facilities, and home health agencies and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

"Health care provider" or **"provider"** means:

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

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

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

"Health carrier" or **"carrier"** means a disability insurer regulated under the law, a health care service contractor, or a health maintenance organization, and includes "issuers" as that term is used in the patient protection and affordable care act.

"Health plan" or **"health benefit plan"** means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services.

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

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

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

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

"Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan.

"Review organization" means a disability insurer, health care service contractor, or health maintenance organization and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

"Small employer" or "small group" means any person, firm, corporation… or self-employed individual that is actively engaged in business that employed at least **one but no more than fifty employees**, during the previous calendar requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: **(a) Have been employed by the same small employer or small group for at least twelve months prior** to application for small group coverage, and **(b)** v**erify that he or she derived at least seventy-five percent of his or her income** from that trade or business.

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

"Standard health questionnaire" means the standard health questionnaire designated under law.

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

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

Definitions. (284-43-5410)

"**Base-benchmark plan"** means the small group plan with the largest enrollment, as designated in WAC 284-43-5600(1) or 284-43-5602(1), prior to any supplementation or adjustments made pursuant to RCW 48.43.715.

"**EHB-benchmark plan**" means the set of benefits that an issuer must include in non-grandfathered plans offered in the individual or small group market in Washington state.

"**Health benefit,"** unless defined differently pursuant to federal rules, regulations, or guidance issued pursuant to section 1302(b) of PPACA, means health care items or services for injury, disease, or a health condition, including a behavioral health condition.

"**Individual plan"** includes any non-grandfathered health benefit plan offered, issued, or renewed by an admitted issuer in the state of Washington for the individual health benefit plan market, unless the certificate of coverage is issued to an individual pursuant to or issued through an organization meeting the definition established pursuant to 29 U.S.C. 1002(5).

"**Mandated benefit"** or "required benefit" means a health plan benefit for a specific type of service, device or medical equipment, or treatment for a specified condition or conditions that a health plan is required to cover by either state or federal law. Required benefits do not include provider, delivery method, or health-status-based requirements.

"Meaningful health benefit" means a benefit that must be included in an essential health benefit category, without which the coverage for the category does not reasonably provide medically necessary services for an individual patient's condition on a nondiscriminatory basis.

"Medical necessity determination process" means the process used by a health issuer to make a coverage determination about whether a health benefit is medically necessary for an individual patient.

"PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

"Scope or limitation requirement" means a requirement applicable to a benefit that limits its duration, the number of times coverage is available for the benefit, or imposes a legally permitted eligibility or reference-based limitation on a specific benefit.

"Small group plan" includes any non-grandfathered health benefit plan offered, issued, or renewed by an admitted issuer in the state of Washington for the small group health benefit plan market to a small group, as defined in RCW 48.43.005, and 45 C.F.R. 144.102(c), unless the certificate of coverage is issued to a small group pursuant to a master contract held by or issued through an organization meeting the definition established pursuant to 29 U.S.C. 1002(5).

"Stand-alone dental plan" means coverage for a set of benefits limited to oral care including, but not necessarily limited to, pediatric oral care, as referenced in RCW 43.71.065.

2. Maternity Services… (48.43.115 3A - 3F)

- ***Maternity services*** include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, hospital services, operating rooms, etc.
- **Coverage for the newly born child must be no less than the coverage of the child's mother**. Adopted children are treated the same as newborns.
- This coverage must permit the attending provider, in consultation with the mother, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers.

3. Independent review of health care disputes… (48.43.535) System for using certified independent review organizations — Rules.

There is a need for a process for the fair consideration of disputes relating to decisions by carriers that offer a health plan to deny, modify, reduce, or terminate coverage of or payment for health care services for an enrollee.

An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service, after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the enrollee, or after the carrier has exceeded the timelines for grievances provided in RCW 48.43.530, without good cause and without reaching a decision.

The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each dispute.

Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of any documentation needed to make a decision:

Enrollees must be provided with at least five business days to submit to the independent review organization in writing additional information that the independent review organization must consider when conducting the external review.

The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington.

Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

- When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.
- Each certified independent review organization must maintain written records and make them available upon request to the commissioner.
- A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

This section is not intended to supplant any existing authority of the office of the insurance commissioner under this title to oversee and enforce carrier compliance with applicable statutes and rules.

4. **Enrollment of Children Under the Parents Health Plan… (48.01.235)** An issuer ***may not deny enrollment*** of a child under the health plan of the child's parent on the grounds that the child:

   - Was born out of wedlock
   - Is not claimed as a dependent on the parent's federal tax return
   - Does not reside with the parent

5. **Prepayment agreements—Standards for forms and documents—Grounds for disapproval—Cancellation or failure to renew—Filing of agreement forms… (48.46.060)**

(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 the 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 concerning 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.

C. Policy Clauses, Exclusions, and Provisions… (48.20.032 through .152)

1. Minimum Standards of Benefits

Proof of Notice… If any notice is mailed to an insured, the insurance company is not required to prove that the insured actually received the notice. It is required to prove only that the notice was mailed to the insured at the last known address.

- ***When a notice to cancel, deny, or refuse to renew insurance is mailed to an insured, the notice must give the actual reason for the notice in clear and simple language. It is not sufficient to state that an insured "does not meet the company's underwriting standards."*** *The reason why the individual does not meet such underwriting standards is what must be given*.

2. The Standard Provisions… (48.20.032 through .152) (a.k.a. Mandatory Policy Provisions)

were put together with the intention of ***protecting the insured (consumer).*** *These 13 Mandatory Provisions will be tested on both the general content portion of the pre-licensing exam as well as the State's Law portion of the disability pre-licensing exam.*

a) The Entire Contract provision states that the contract is made up of the policy, application, endorsements, and riders. All statements in the application will be deemed ***representations*** (statements believed to be true) and not *warranties* (policy statements guaranteed to be true).

- The contract may not be changed unilaterally once it is issued. No changes are valid unless approved and endorsed by an executive officer of the insurer. No insurance producer has the authority to change this policy or to waive any of its provisions.
- The purpose of the provision is to assure the policy owner that he has in his possession all necessary documents concerning his insurance coverage.

b) Time Limit on Certain Defenses, a.k.a. ***Incontestability Period***, states that after a policy has been in force for **two years (from the date of issue)**, the insurer cannot contest or void the claim, nor can it cancel the policy other than for **non-payment of premium or fraud committed by the insured such as filing a false claim**.

Reasons the policy can be canceled in the first two years:

- If a policy is canceled or a claim is voided for **material misrepresentation or concealment,** all paid premiums must be refunded (**no interest**) to the policy owner.
- ***Concealment*** is the ***withholding of facts*** from an insurance company. An example is not telling the insurer at the time of the application that you are leaving the field of accounting (a low-risk occupation) and will be starting your logging business (a high-risk occupation) in the next few months. *A lie* told by the applicant to the insurance company is a ***misrepresentation***.
- ***Material fact*** is information that, had it been known, would have caused the insurer to reject the application or issue the policy on ***substantially different terms*** *(e.g., a rate-up, surcharge, or exclusion rider).*

c) **Grace Period** extends coverage past the due date. Claims are still covered minus the past due premium, but ***no interest is charged*** to the insured. The Grace Period must be no less than **seven days** for weekly payment plans, **10 days** for monthly payment plans, and **31 days** for payment plans over 30 days.

d) **Reinstatement** allows a lapsed policy to be put back in force. However, an application for reinstatement might be required. The insurer must respond within 45 days of the reinstatement application or the policy is automatically reinstated.

e) **Notice of Claim…** A written notice of claim must be given to the insurer within **20 days** after the date of loss, if reasonably possible. Notifying the agent is acceptable. In the event of legal **incapacity,** this provision will be waived.

f) **Claim Forms** are used by the insured to file proof of loss. The insurer should send the claim form within **15 days** after the notice of claim. If the forms are not furnished, the insured may submit a written statement to the insurance company to satisfy the proof of loss.

g) **Proof of Loss** states that the insured or claimant has **90 days** to file a proof of loss with the insurer from the date of loss. In the event of legal **incapacity,** this provision could be extended for up to one year or waived entirely.

h) **Time of Payment of Claim** states that the insurer must pay claims ***immediately*** after receipt of proof of loss, except for claims involving periodic payments, such as disability income policies. Disability income (*loss-of-time*) benefits must be paid **at least monthly**.

i) **Payment of Claims** will be made to the **owner**, beneficiary, or the insured's estate if there is no beneficiary. Indemnity for loss of life will be paid to the designated beneficiary. Indemnities for hospital, nursing, medical, or surgical services may be paid directly to the health care provider (a.k.a. Assignment of Benefits).

j) **Physical Exam/Autopsy** states that the insurer may require a physical exam of the insured at **reasonable** intervals (usually every six months) should the insured be receiving benefits. ***In the event of the death of the insured, an autopsy may be sought at the insurance company's expense, unless prohibited by law.***

k) **Legal Actions** provision requires that ***no legal action be started*** against the insurance company to collect benefits sooner than **60 days** *after the proof of loss is filed with the insurer.* This waiting period allows the insurer time to evaluate the claim. The statute of limitations is **three years** from the date the proof of loss is filed with the insurer.

l) **Change of (Revocable) Beneficiary** is the policy owner's right. For the change to be effective, it must be in writing by the owner and approved by the insurer in the form of an endorsement. A beneficiary is a party to whom the benefits of a policy are payable.

m) **Misstatement of Age/Gender (Sex)** provision states that **benefits will be adjusted** so the insurer pays for the benefit the premium would have purchased had the correct age or sex been known. ***Time Limit on Certain Defenses does not apply to this provision***. This is not a material fact, so the company cannot cancel the policy nor are they bound to two years to discover the misstatement.

3. **Free Look (Return of Policy)…** This provision gives the owner of any disability contract a ***minimum*** of **10 days** to look at the policy from the date the policy is ***delivered to the owner***. This provision gives the owner the right to return the policy for a ***full refund***. The insurance company has **30 days to refund** the paid premiums or pay an additional **10% penalty** to the insured.

    - Medicare supplement policies require a minimum of 30 days of free-look (instead of 10 days) or the right to return the policy.

4. Discrimination prohibited… (48.44.220)

No health care service contractor shall deny coverage to any person solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical disability *(handicap)*. Nothing in this section shall be construed as limiting a healthcare service contractor'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 healthcare service contractor for purposes of determining coverage for any person.

No health care service contractor shall refuse to provide reimbursement or indemnity to any person for covered health care services for reasons that the health care services were provided by a holder of a license under chapter 18.22 RCW.

- **This does not affect the right of the insurance company to increase rates** (premiums). With the permission of the Insurance Commissioner, a rate increase must be on a classification basis, not on an individual basis.

5. Nondiscrimination in health plans, short-term limited duration medical plans and student-only health plans. (284-43-5940)

An issuer offering a plan, and the issuer's officials, employees, agents, or representatives may not:

(i) Discriminate based on race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(ii) Deny, cancel, limit, or refuse to issue or renew a plan, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, based on race, color, national origin, sex, gender identity, sexual orientation, age, or disability;

(iii) Have or implement marketing practices or benefit designs that discriminate based on race, color, national origin, sex, gender identity, sexual orientation, age, or disability. In reviewing plan design, plan features that attempt to circumvent coverage of medically necessary benefits such as by labeling a benefit as a pediatric service, thereby excluding adults, or by placing all or most drugs for a specific condition in the highest cost-sharing tier, absent an appropriate reason for the exclusion, are potentially discriminatory. In these or other instances, the commissioner may request a justification for the practice. If requested, issuers must identify an appropriate, nondiscriminatory reason that supports their benefit design;

D. HCSC (Health Care Svc Contractor) and HMO (Health Maintenance Org)

1. Definitions… (48.44.010, 48.46.020)

"**Health care service contractor**" means any corporation, cooperative group, or association, which is ***sponsored by or connected with a provider or group of providers***, who accepts consideration (premium payment) for providing such persons with any health care services. *(e.g., Premera Blue Cross and Regence Blue Shield.)*

"**Health maintenance organization**" means any organization that provides comprehensive health care services to enrolled participants on a ***per capita prepayment basis or a prepaid individual practice plan***, except for an enrolled participant's responsibility for **copayments**. *(e.g., Kaiser Permanente.)*

"**Health care services**" means and includes medical, surgical, dental, **chiropractic**, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

"**Participating provider**" means a provider who has contracted in writing with a health care service contractor to accept payment from such contractor for any health care services rendered to a person. *(E.g., the Everett Clinic, a doctor, or a hospital.)*

2. Conversion/Continuation Rights… (48.44.360, 48.46.440, 48.21.250)

Individual and group disability insurance policies must provide that the covered spouse and/or dependents may continue the coverage under a new policy, ***without evidence of insurability***, if they cease to be a family member because of divorce or death of the insured, or the child reaches the limiting age (currently age 26).

Dependent Children… Disabled *(handicapped)* children ***may not be removed from the parent's policy***. Proof of incapacity for the continuance of benefits for such dependents must be given within **31 days** from when the dependent reaches the limiting age. *The insurer may require proof anytime for the first two years and once per year after that*.

- The dependent must be incapable of self-sustaining employment and chiefly dependent upon the parents or guardians for support and maintenance.

Continuation option to be offered. Every insurer that issues policies providing group coverage for hospital or medical expenses shall offer the policyholder an option to include a policy provision granting a person who becomes ineligible for coverage under the group policy, the right to continue the group benefits for a period of time and at a rate agreed upon. The policy provision shall provide that when such coverage terminates, the covered person may convert to a policy.

3. Coverage of Newborns… (48.46.250)

Newborns ***are*** **covered at birth** ***on all individual and group disability insurance policies.*** The insured must pay the premium and fill out the necessary forms within **60 days of birth. Adopted children are treated the same as newborns.**

4. Coverage for Children… (48.44.215)

Each individual or group health care plan that is not grandfathered and provides coverage for a subscriber or participating member, must offer the option of covering any child under the age of twenty-six. A health care service plan that *is* grandfathered must offer the option of covering any child under the age of twenty-six unless the child is eligible to enroll in an eligible health plan sponsored by their employer or their spouse's employer.

II. Federal Laws

A. Fair Credit Reporting Act… Consumer Report / Credit Check says any report may be run by the insurance company when underwriting an application, however:

1. The consumer must be notified that a credit report or any other report will be sought and told how it will be used. You must be told if information in your file has been used against you.
2. You have the right to ask for your (credit) score.
3. The consumer must be told how to obtain a copy of their report. The consumer has the right to know what is on the report.
4. Information on the report can be disputed, and if the reporting agency cannot prove the disputed information is accurate, the information must be removed from the person's file within 30 days.
5. **A Bankruptcy will show for 7 to 10 years on your credit report (7 years if the debt was paid, 10 if it was not).**

B. Fraud and false statements (18 USC Sections 1033 and 1034), A.K.A. the Violent Crime Control and Law Enforcement Act:

1033… It is a criminal offense for an individual who has been convicted of a felony involving dishonesty or breach of trust to willfully engage or participate (in any capacity) in the business of insurance without first obtaining a **"Letter of Written Consent to Engage in the Business of Insurance"** from the regulating insurance department of the individual's state of residence. Such a "prohibited person" is required to submit a written request to the **Commissioner of Insurance** and the Commissioner of Commerce for permission prior to doing business.

1034… The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting an offense under section 1033 and, upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty of not more than $50,000 for each violation or the amount of compensation which the person received or offered for the prohibited conduct, whichever amount is greater.

Insurance companies, as well as persons employing anyone to conduct the business of insurance, may be in violation of this Code if they willfully permit participation by a prohibited person. It is the responsibility of the employer to ensure that any prohibited person who they employ is not permitted to conduct the business of insurance affecting interstate commerce without written consent.

C. The Affordable Health Care Act is a comprehensive health care reform enacted in 2010. There were 3 primary goals of this law, make health care more affordable to more people, expand the Medicaid program, and support innovative medical care delivery methods. It required every citizen to get and maintain health insurance or pay a penalty. The penalty dropped in 2018. It also stopped exclusions for pre-existing conditions in health care. More details are found in the Medical Plans chapter.

D. Privacy – Gramm-Leach-Bliley The GBL act is intended to limit the instances when a financial institution is allowed to share a client's financial information with non-affiliated third parties. The client has the option to "opt out" of the sharing if an institution does share with third parties. A financial group may share "in-house" and you cannot opt out of that.

E. National Do Not Call List

- DNC is managed by the FTC (Federal Trade Commission) and is to limit access to consumers who have indicated their preference to limit telemarketing calls received. *Businesses selling anything must utilize the list prior to calling and if it is downloaded it must be updated monthly*.
- Businesses are given 5 area codes and must purchase an annual subscription to any others.
- A company with which a consumer has an established business relationship may call for up to 18 months after the consumer's last purchase or last delivery, or last payment, unless the consumer asks the company not to call again.
- Violations may be subject to a fine of up to **$46,517.**
- If a consumer makes an inquiry or submits an application to a company, the company can call for three months.
- No sales calls may be made before **8 A.M. or after 9 P.M.** and the caller ID must show the solicitor's name and number.
- A consumer whose number is not on the national registry can still prohibit individual telemarketers from calling by asking to be put on the company's own do not call list.
- The do not call provisions do not cover calls from political organizations, charities, telephone surveyors, or companies with which a consumer has an existing business relationship
- Consumers can register online and get more information at DoNotCall.gov

F. CAN-SPAM Act

- The CAN-SPAM act does for emails what the Do Not Call List does for phone calls.
- The maximum fine is the same (46,517).
- It applies to all emails sent by businesses. The main requirements are:
  1. Don't use false or misleading header information.
  2. Don't use deceptive subject lines.
  3. Identify the message as an ad.
  4. Tell recipients where you're located.
  5. Tell recipients how to opt out of receiving future emails from you.
  6. Honor opt-out requests promptly.
  7. Monitor what others are doing on your behalf.
- **Anyone opting out must be removed from the list within 10 days.**