S-4675.1

SUBSTITUTE SENATE BILL 6538

State of Washington 61st Legislature 2010 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser and Pflug)

READ FIRST TIME 02/05/10.

1 AN ACT Relating to the definition of small groups for insurance
2 purposes; amending RCW 48.43.035; reenacting and amending RCW
3 48.43.005; and creating a new section.

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

5 **Sec. 1.** RCW 48.43.005 and 2008 c 145 s 20 and 2008 c 144 s 1 are
6 each reenacted and amended to read as follows:
7 Unless otherwise specifically provided, the definitions in this
8 section apply throughout this chapter.
9 (1) "Adjusted community rate" means the rating method used to
10 establish the premium for health plans adjusted to reflect actuarially
11 demonstrated differences in utilization or cost attributable to
12 geographic region, age, family size, and use of wellness activities.
13 (2) "Basic health plan" means the plan described under chapter
14 70.47 RCW, as revised from time to time.
15 (3) "Basic health plan model plan" means a health plan as required
16 in RCW 70.47.060(2)(e).
17 (4) "Basic health plan services" means that schedule of covered
18 health services, including the description of how those benefits are to

be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least six thousand dollars, both amounts to be adjusted annually by the insurance commissioner; or

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

In July 2008, and in each July thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. The adjusted amount shall apply on the following January 1st.

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

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

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

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

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

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

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

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

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

33 (15) "Health care facility" or "facility" means hospices licensed
34 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
35 rural health care facilities as defined in RCW 70.175.020, psychiatric
36 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
37 under chapter 18.51 RCW, community mental health centers licensed under
38 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed

under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

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

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

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

(17) "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.

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

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

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

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

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

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least ((~~two~~)) one but no more than fifty employees, during the previous calendar year and employed at least ((~~two~~)) one employee((~~s~~)) on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In

determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor ((~~who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6)~~)) 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) have the department of revenue verify for the carrier that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(25) "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.

(26) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the

purpose of improving enrollee health status and reducing health service costs.

Sec. 2. RCW 48.43.035 and 2004 c 244 s 4 are each amended to read as follows:

For group health benefit plans, the following shall apply:

(1) All health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) Except as provided in subsection (5) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. The carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

(3) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment

amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

(4) The provisions of this section do not apply in the following cases:

(a) A carrier has zero enrollment on a product;

(b) A carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product;

(c) No sooner than January 1, 2005, a carrier discontinues offering a particular type of health benefit plan offered for groups of up to two hundred if: (i) The carrier provides notice to each group of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll, with regard to small employer groups, in any other small employer group plan, or with regard to groups of up to two hundred, in any other applicable group plan, currently being offered by the carrier in the applicable group market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage;

(d) A carrier discontinues offering all health coverage in the small group market or for groups of up to two hundred, or both markets, in the state and discontinues coverage under all existing group health benefit plans in the applicable market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the

carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any group health coverage in this state in the applicable group market involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

(e) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the insurance commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded.

(5) The provisions of this section do not apply to health plans deemed by the insurance commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(6) Notwithstanding any other provision of this section, the guarantee of continuity of coverage applies to a group of one only if: (a) The carrier continues to offer any other small employer group plan in which the group of one was eligible to enroll on the day prior to June 10, 2004; and (b) the person continues to qualify as a group of one under the criteria in place on the day prior to June 10, 2004.~~))

NEW SECTION. **Sec. 3.** This act applies to small group policies issued or renewed on or after January 1, 2011.

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