

---

SENATE BILL 6538

---

State of Washington

61st Legislature

2010 Regular Session

By Senators Keiser and Pflug

Read first time 01/18/10. Referred to Committee on Health & Long-Term Care.

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 providing an effective date.

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

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

3 (5) "Catastrophic health plan" means:

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

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

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

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

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

36 (7) "Concurrent review" means utilization review conducted during  
37 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

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

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

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

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

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

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

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

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

26 (b) Medicare supplemental health insurance governed by chapter  
27 48.66 RCW;

28 (c) Coverage supplemental to the coverage provided under chapter  
29 55, Title 10, United States Code;

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

32 (e) Disability income;

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

36 (g) Workers' compensation coverage;

37 (h) Accident only coverage;

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

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

5 (k) Dental only and vision only coverage; and

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

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

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

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

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

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

1 determining the number of employees, companies that are affiliated  
2 companies, or that are eligible to file a combined tax return for  
3 purposes of taxation by this state, shall be considered an employer.  
4 Subsequent to the issuance of a health plan to a small employer and for  
5 the purpose of determining eligibility, the size of a small employer  
6 shall be determined annually. Except as otherwise specifically  
7 provided, a small employer shall continue to be considered a small  
8 employer until the plan anniversary following the date the small  
9 employer no longer meets the requirements of this definition. ((A  
10 self-employed individual or sole proprietor who is covered as a group  
11 of one on the day prior to June 10, 2004, shall also be considered a  
12 "small employer" to the extent that individual or group of one is  
13 entitled to have his or her coverage renewed as provided in RCW  
14 48.43.035(6).))

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

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

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

29 For group health benefit plans, the following shall apply:

30 (1) All health carriers shall accept for enrollment any state  
31 resident within the group to whom the plan is offered and within the  
32 carrier's service area and provide or assure the provision of all  
33 covered services regardless of age, sex, family structure, ethnicity,  
34 race, health condition, geographic location, employment status,  
35 socioeconomic status, other condition or situation, or the provisions  
36 of RCW 49.60.174(2). The insurance commissioner may grant a temporary  
37 exemption from this subsection, if, upon application by a health

1 carrier the commissioner finds that the clinical, financial, or  
2 administrative capacity to serve existing enrollees will be impaired if  
3 a health carrier is required to continue enrollment of additional  
4 eligible individuals.

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

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

16 (a) Nonpayment of premium;

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

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

23 (d) Covered persons who fail to pay any deductible or copayment  
24 amount owed to the carrier and not the provider of health care  
25 services;

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

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

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

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

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

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

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

15 (d) A carrier discontinues offering all health coverage in the  
16 small group market or for groups of up to two hundred, or both markets,  
17 in the state and discontinues coverage under all existing group health  
18 benefit plans in the applicable market involved if: (i) The carrier  
19 provides notice to the commissioner of its intent to discontinue  
20 offering all such coverage in the state and its intent to discontinue  
21 coverage under all such existing health benefit plans at least one  
22 hundred eighty days prior to the date of the discontinuation of  
23 coverage under all such existing health benefit plans; and (ii) the  
24 carrier provides notice to each covered group of the intent to  
25 discontinue the existing health benefit plan at least one hundred  
26 eighty days prior to the date of discontinuation. In the case of  
27 discontinuation under this subsection, the carrier may not issue any  
28 group health coverage in this state in the applicable group market  
29 involved for a five-year period beginning on the date of the  
30 discontinuation of the last health benefit plan not so renewed. This  
31 subsection (4) does not require a carrier to provide notice to the  
32 commissioner of its intent to discontinue offering a health benefit  
33 plan to new applicants when the carrier does not discontinue coverage  
34 of existing enrollees under that health benefit plan; or

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



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

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

12           NEW SECTION.   **Sec. 3.** This act takes effect January 1, 2011.

--- END ---