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**SENATE BILL 5595**

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**State of Washington 64th Legislature 2015 Regular Session**

**By** Senators Becker and Bailey

AN ACT Relating to clarifying association health plans provisions; amending RCW 48.21.010, 48.44.070, and 48.46.060; creating new sections; and providing an effective date.

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

NEW SECTION. **Sec.**  The legislature finds that the offering of affordable health care to Washington residents is a critical public policy objective. The legislature further finds that as the affordable care act is fully implemented, it is critical that quality health care coverage continue to be available to residents of the state. The legislature further finds that association health care plans are an important means of delivering quality and affordable health care coverage and that continuation of such plans will help mitigate the costs of implementing the affordable care act. Therefore, the legislature declares that association health care plans meeting certain standards should be continued as a means of providing health care as the affordable care act is implemented.

**Sec.**  RCW 48.21.010 and 2011 c 81 s 1 are each amended to read as follows:

(1) Group disability insurance is that form of disability insurance, including stop loss insurance as defined in RCW 48.11.030, provided by a master policy issued to an employer, to a trustee appointed by an employer or employers, or to an association of employers formed for purposes other than obtaining such insurance, covering, with or without their dependents, the employees, or specified categories of the employees, of such employers or their subsidiaries or affiliates, or issued to a labor union, or to an association of employees formed for purposes other than obtaining such insurance, covering, with or without their dependents, the members, or specified categories of the members, of the labor union or association, or issued pursuant to RCW 48.21.030. Group disability insurance includes the following groups that qualify for group life insurance:

RCW 48.24.020, 48.24.035, 48.24.040, 48.24.045, 48.24.050, 48.24.060, 48.24.070, 48.24.080, 48.24.090, and 48.24.095. A group under RCW 48.24.027 does not qualify as a group for the purposes of this chapter.

(2) Group disability insurance for lines of coverage identified in RCW 48.43.005((~~(19)~~)) (26) (e), (h), and (k) offered to a resident of this state under a group disability insurance policy may be issued to a group other than the groups described in subsection (1) of this section subject to the requirements in this subsection.

(a) A group disability insurance policy offered under this subsection may not be delivered in this state unless the commissioner finds that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premium charged.

(b) A group disability insurance coverage may not be offered under this subsection in this state by an insurer under a policy issued in another state unless the commissioner or the insurance commissioner of another state having requirements substantially similar to those contained in this subsection has made a determination that the requirements have been met.

(3) Until or unless the United States department of labor prohibits the treatment of a health plan issued to an association or member-governed group as a large group plan, any rate or form filed by any life and disability carrier for health benefit coverage to employers purchasing health plans through that association and member-governed group shall be deemed and may only be reviewed as a negotiated large group filing by the insurance commissioner if the carrier in good faith certifies that:

(a) The association or member-governed group operates solely within the borders of a single state and only includes member employers having registered Washington state unified business identifiers;

(b) The association or member-governed group has minimum enrollment of one hundred participants;

(c) Any filed health plan includes all benefit mandates applicable to fully insured large group health plans;

(d) A filed health plan will not underwrite individuals based upon health conditions of the individual;

(e) A filed health plan will not be issued to any association that conditions membership based on age, health status, or medical claims experience; and

(f) A filed health plan will be offered to all eligible association members, regardless of their age, health status, or medical claims experience.

**Sec.**  RCW 48.44.070 and 1990 c 120 s 9 are each amended to read as follows:

(1) Forms of contracts between health care service contractors and participating providers shall be filed with the insurance commissioner prior to use.

(2) Any contract form not affirmatively disapproved within fifteen days of filing shall be deemed approved, except that the commissioner may extend the approval period an additional fifteen days upon giving notice before the expiration of the initial fifteen-day period. The commissioner may approve such a contract form for immediate use at any time. Approval may be subsequently withdrawn for cause.

(3) Until or unless the United States department of labor prohibits the treatment of a health plan issued to an association or member-governed group as a large group plan, any rate or form filed by any health care service contractor for health benefit coverage to employers purchasing health plans through that association and member-governed group shall be deemed and may only be reviewed as a negotiated large group filing by the insurance commissioner if the carrier in good faith certifies that:

(a) The association or member-governed group operates solely within the borders of a single state and only includes member employers having registered Washington state unified business identifiers;

(b) The association or member-governed group has minimum enrollment of one hundred participants;

(c) Any filed health plan includes all benefit mandates applicable to fully insured large group health plans;

(d) A filed health plan will not underwrite individuals based upon health conditions of the individual;

(e) A filed health plan will not be issued to any association that conditions membership based on age, health status, or medical claims experience; and

(f) A filed health plan will be offered to all eligible association members, regardless of their age, health status, or medical claims experience.

(4) Subject to the right of the health care service contractor to demand and receive a hearing and an automatic stay under chapters 48.04 and 34.05 RCW, the commissioner may disapprove such a contract form 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.

**Sec.**  RCW 48.46.060 and 2008 c 303 s 3 are each amended to read as follows:

(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) Until or unless the United States department of labor prohibits the treatment of a health plan issued to an association or member-governed group as a large group plan, any rate or form filed by any health maintenance organization for health benefit coverage to employers purchasing health plans through that association and member-governed group shall be deemed and may only be reviewed as a negotiated large group filing by the insurance commissioner if the carrier in good faith certifies that:

(a) The association or member-governed group operates solely within the borders of a single state and only includes member employers having registered Washington state unified business identifiers;

(b) The association or member-governed group has minimum enrollment of one hundred participants;

(c) Any filed health plan includes all benefit mandates applicable to fully insured large group health plans;

(d) A filed health plan will not underwrite individuals based upon health conditions of the individual;

(e) A filed health plan will not be issued to any association that conditions membership based on age, health status, or medical claims experience; and

(f) A filed health plan will be offered to all eligible association members, regardless of their age, health status, or medical claims experience.

(4) Subject to the right of the health maintenance organization to demand and receive a hearing and an automatic stay 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)~~)) (5) 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)~~)) (6) 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)~~)) (7) No agreement form or amendment to an approved agreement form shall be used unless it is first filed with the commissioner.

NEW SECTION. **Sec.**  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.

NEW SECTION. **Sec.**  If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

NEW SECTION. **Sec.**  The commissioner shall take the necessary steps to ensure that this act is implemented on its effective date.

NEW SECTION. **Sec.**  Section 3 of this act takes effect July 1, 2017.

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