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SENATE BILL 5523

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State of Washington                      60th Legislature                      2007 Regular Session

By Senators Franklin, Carrell, Keiser, Prentice, Berkey and Parlette

Read first time 01/23/2007. Referred to Committee on Health & Long-Term Care.

1            AN ACT Relating to specified disease, hospital confinement, or  
2 other fixed payment insurance; and amending RCW 48.43.005.

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

4            **Sec. 1.** RCW 48.43.005 and 2006 c 25 s 16 are each amended to read  
5 as follows:

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

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

12            (2) "Basic health plan" means the plan described under chapter  
13 70.47 RCW, as revised from time to time.

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

16            (4) "Basic health plan services" means that schedule of covered  
17 health services, including the description of how those benefits are to  
18 be administered, that are required to be delivered to an enrollee under  
19 the basic health plan, as revised from time to time.

1 (5) "Catastrophic health plan" means:

2 (a) In the case of a contract, agreement, or policy covering a  
3 single enrollee, a health benefit plan requiring a calendar year  
4 deductible of, at a minimum, one thousand five hundred dollars and an  
5 annual out-of-pocket expense required to be paid under the plan (other  
6 than for premiums) for covered benefits of at least three thousand  
7 dollars; and

8 (b) In the case of a contract, agreement, or policy covering more  
9 than one enrollee, a health benefit plan requiring a calendar year  
10 deductible of, at a minimum, three thousand dollars and an annual out-  
11 of-pocket expense required to be paid under the plan (other than for  
12 premiums) for covered benefits of at least five thousand five hundred  
13 dollars; or

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

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

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

27 (8) "Covered person" or "enrollee" means a person covered by a  
28 health plan including an enrollee, subscriber, policyholder,  
29 beneficiary of a group plan, or individual covered by any other health  
30 plan.

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

34 (10) "Eligible employee" means an employee who works on a full-time  
35 basis with a normal work week of thirty or more hours. The term  
36 includes a self-employed individual, including a sole proprietor, a  
37 partner of a partnership, and may include an independent contractor, if  
38 the self-employed individual, sole proprietor, partner, or independent

1 contractor is included as an employee under a health benefit plan of a  
2 small employer, but does not work less than thirty hours per week and  
3 derives at least seventy-five percent of his or her income from a trade  
4 or business through which he or she has attempted to earn taxable  
5 income and for which he or she has filed the appropriate internal  
6 revenue service form. Persons covered under a health benefit plan  
7 pursuant to the consolidated omnibus budget reconciliation act of 1986  
8 shall not be considered eligible employees for purposes of minimum  
9 participation requirements of chapter 265, Laws of 1995.

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

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

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

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

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

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

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

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

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

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

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

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

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

24 (b) Medicare supplemental health insurance governed by chapter  
25 48.66 RCW;

26 (c) Coverage supplemental to the coverage provided under chapter  
27 55, Title 10, United States Code;

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

30 (e) Disability income;

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

34 (g) Workers' compensation coverage;

35 (h) Accident only coverage;

36 (i) Specified disease (~~and~~) or illness-triggered fixed payment  
37 insurance, hospital confinement (~~indemnity when marketed solely as a~~

1 ~~supplement to a health plan))~~ fixed payment insurance, or other fixed  
2 payment insurance offered as an independent, noncoordinated benefit;

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

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

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

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

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

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

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

30 (24) "Small employer" or "small group" means any person, firm,  
31 corporation, partnership, association, political subdivision, sole  
32 proprietor, or self-employed individual that is actively engaged in  
33 business that, on at least fifty percent of its working days during the  
34 preceding calendar quarter, employed at least two but no more than  
35 fifty eligible employees, with a normal work week of thirty or more  
36 hours, the majority of whom were employed within this state, and is not  
37 formed primarily for purposes of buying health insurance and in which  
38 a bona fide employer-employee relationship exists. In determining the

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

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

30 (26) "Wellness activity" means an explicit program of an activity  
31 consistent with department of health guidelines, such as, smoking  
32 cessation, injury and accident prevention, reduction of alcohol misuse,  
33 appropriate weight reduction, exercise, automobile and motorcycle  
34 safety, blood cholesterol reduction, and nutrition education for the  
35 purpose of improving enrollee health status and reducing health service  
36 costs.

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