
SENATE BILL 6051

State of Washington

66th Legislature

2020 Regular Session

By Senators Cleveland, O'Ban, Becker, and Wilson, C.

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1 AN ACT Relating to health coverage that is supplemental to the
2 coverage provided under an employer or union-sponsored prescription
3 drug coverage that supplements medicare part D provided through an
4 employer group waiver plan authorized under federal law; amending RCW
5 48.43.733; and reenacting and amending RCW 48.43.005.

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

7 **Sec. 1.** RCW 48.43.005 and 2019 c 427 s 2, 2019 c 56 s 2, and
8 2019 c 33 s 1 are each reenacted and amended to read as follows:

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

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

16 (2) "Adverse benefit determination" means a denial, reduction, or
17 termination of, or a failure to provide or make payment, in whole or
18 in part, for a benefit, including a denial, reduction, termination,
19 or failure to provide or make payment that is based on a
20 determination of an enrollee's or applicant's eligibility to
21 participate in a plan, and including, with respect to group health

1 plans, a denial, reduction, or termination of, or a failure to
2 provide or make payment, in whole or in part, for a benefit resulting
3 from the application of any utilization review, as well as a failure
4 to cover an item or service for which benefits are otherwise provided
5 because it is determined to be experimental or investigational or not
6 medically necessary or appropriate.

7 (3) "Allowed amount" means the maximum portion of a billed charge
8 a health carrier will pay, including any applicable enrollee cost-
9 sharing responsibility, for a covered health care service or item
10 rendered by a participating provider or facility or by a
11 nonparticipating provider or facility.

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

15 (5) "Balance bill" means a bill sent to an enrollee by an out-of-
16 network provider or facility for health care services provided to the
17 enrollee after the provider or facility's billed amount is not fully
18 reimbursed by the carrier, exclusive of permitted cost-sharing.

19 (6) "Basic health plan" means the plan described under chapter
20 70.47 RCW, as revised from time to time.

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

23 (8) "Basic health plan services" means that schedule of covered
24 health services, including the description of how those benefits are
25 to be administered, that are required to be delivered to an enrollee
26 under the basic health plan, as revised from time to time.

27 (9) "Board" means the governing board of the Washington health
28 benefit exchange established in chapter 43.71 RCW.

29 (10)(a) For grandfathered health benefit plans issued before
30 January 1, 2014, and renewed thereafter, "catastrophic health plan"
31 means:

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

39 (ii) In the case of a contract, agreement, or policy covering
40 more than one enrollee, a health benefit plan requiring a calendar

1 year deductible of, at a minimum, three thousand five hundred dollars
2 and an annual out-of-pocket expense required to be paid under the
3 plan (other than for premiums) for covered benefits of at least six
4 thousand dollars, both amounts to be adjusted annually by the
5 insurance commissioner.

6 (b) In July 2008, and in each July thereafter, the insurance
7 commissioner shall adjust the minimum deductible and out-of-pocket
8 expense required for a plan to qualify as a catastrophic plan to
9 reflect the percentage change in the consumer price index for medical
10 care for a preceding twelve months, as determined by the United
11 States department of labor. For a plan year beginning in 2014, the
12 out-of-pocket limits must be adjusted as specified in section
13 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
14 shall apply on the following January 1st.

15 (c) For health benefit plans issued on or after January 1, 2014,
16 "catastrophic health plan" means:

17 (i) A health benefit plan that meets the definition of
18 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
19 2010, as amended; or

20 (ii) A health benefit plan offered outside the exchange
21 marketplace that requires a calendar year deductible or out-of-pocket
22 expenses under the plan, other than for premiums, for covered
23 benefits, that meets or exceeds the commissioner's annual adjustment
24 under (b) of this subsection.

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

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

33 (13) "Covered person" or "enrollee" means a person covered by a
34 health plan including an enrollee, subscriber, policyholder,
35 beneficiary of a group plan, or individual covered by any other
36 health plan.

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

1 (15) "Emergency medical condition" means a medical, mental
2 health, or substance use disorder condition manifesting itself by
3 acute symptoms of sufficient severity including, but not limited to,
4 severe pain or emotional distress, such that a prudent layperson, who
5 possesses an average knowledge of health and medicine, could
6 reasonably expect the absence of immediate medical, mental health, or
7 substance use disorder treatment attention to result in a condition
8 (a) placing the health of the individual, or with respect to a
9 pregnant woman, the health of the woman or her unborn child, in
10 serious jeopardy, (b) serious impairment to bodily functions, or (c)
11 serious dysfunction of any bodily organ or part.

12 (16) "Emergency services" means a medical screening examination,
13 as required under section 1867 of the social security act (42 U.S.C.
14 1395dd), that is within the capability of the emergency department of
15 a hospital, including ancillary services routinely available to the
16 emergency department to evaluate that emergency medical condition,
17 and further medical examination and treatment, to the extent they are
18 within the capabilities of the staff and facilities available at the
19 hospital, as are required under section 1867 of the social security
20 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
21 respect to an emergency medical condition, has the meaning given in
22 section 1867(e)(3) of the social security act (42 U.S.C.
23 1395dd(e)(3)).

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

27 (18) "Enrollee point-of-service cost-sharing" or "cost-sharing"
28 means amounts paid to health carriers directly providing services,
29 health care providers, or health care facilities by enrollees and may
30 include copayments, coinsurance, or deductibles.

31 (19) "Essential health benefit categories" means:

32 (a) Ambulatory patient services;

33 (b) Emergency services;

34 (c) Hospitalization;

35 (d) Maternity and newborn care;

36 (e) Mental health and substance use disorder services, including
37 behavioral health treatment;

38 (f) Prescription drugs;

39 (g) Rehabilitative and habilitative services and devices;

40 (h) Laboratory services;

1 (i) Preventive and wellness services and chronic disease
2 management; and

3 (j) Pediatric services, including oral and vision care.

4 (20) "Exchange" means the Washington health benefit exchange
5 established under chapter 43.71 RCW.

6 (21) "Final external review decision" means a determination by an
7 independent review organization at the conclusion of an external
8 review.

9 (22) "Final internal adverse benefit determination" means an
10 adverse benefit determination that has been upheld by a health plan
11 or carrier at the completion of the internal appeals process, or an
12 adverse benefit determination with respect to which the internal
13 appeals process has been exhausted under the exhaustion rules
14 described in RCW 48.43.530 and 48.43.535.

15 (23) "Grandfathered health plan" means a group health plan or an
16 individual health plan that under section 1251 of the patient
17 protection and affordable care act, P.L. 111-148 (2010) and as
18 amended by the health care and education reconciliation act, P.L.
19 111-152 (2010) is not subject to subtitles A or C of the act as
20 amended.

21 (24) "Grievance" means a written complaint submitted by or on
22 behalf of a covered person regarding service delivery issues other
23 than denial of payment for medical services or nonprovision of
24 medical services, including dissatisfaction with medical care,
25 waiting time for medical services, provider or staff attitude or
26 demeanor, or dissatisfaction with service provided by the health
27 carrier.

28 (25) "Health care facility" or "facility" means hospices licensed
29 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
30 rural health care facilities as defined in RCW 70.175.020,
31 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
32 licensed under chapter 18.51 RCW, community mental health centers
33 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
34 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
35 treatment, or surgical facilities licensed under chapter 70.41 RCW,
36 drug and alcohol treatment facilities licensed under chapter 70.96A
37 RCW, and home health agencies licensed under chapter 70.127 RCW, and
38 includes such facilities if owned and operated by a political
39 subdivision or instrumentality of the state and such other facilities
40 as required by federal law and implementing regulations.

1 (26) "Health care provider" or "provider" means:
2 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
3 practice health or health-related services or otherwise practicing
4 health care services in this state consistent with state law; or
5 (b) An employee or agent of a person described in (a) of this
6 subsection, acting in the course and scope of his or her employment.
7 (27) "Health care service" means that service offered or provided
8 by health care facilities and health care providers relating to the
9 prevention, cure, or treatment of illness, injury, or disease.
10 (28) "Health carrier" or "carrier" means a disability insurer
11 regulated under chapter 48.20 or 48.21 RCW, a health care service
12 contractor as defined in RCW 48.44.010, or a health maintenance
13 organization as defined in RCW 48.46.020, and includes "issuers" as
14 that term is used in the patient protection and affordable care act
15 (P.L. 111-148).
16 (29) "Health plan" or "health benefit plan" means any policy,
17 contract, or agreement offered by a health carrier to provide,
18 arrange, reimburse, or pay for health care services except the
19 following:
20 (a) Long-term care insurance governed by chapter 48.84 or 48.83
21 RCW;
22 (b) Medicare supplemental health insurance governed by chapter
23 48.66 RCW;
24 (c) Coverage supplemental to the coverage provided under chapter
25 55, Title 10, United States Code;
26 (d) Limited health care services offered by limited health care
27 service contractors in accordance with RCW 48.44.035;
28 (e) Disability income;
29 (f) Coverage incidental to a property/casualty liability
30 insurance policy such as automobile personal injury protection
31 coverage and homeowner guest medical;
32 (g) Workers' compensation coverage;
33 (h) Accident only coverage;
34 (i) Specified disease or illness-triggered fixed payment
35 insurance, hospital confinement fixed payment insurance, or other
36 fixed payment insurance offered as an independent, noncoordinated
37 benefit;
38 (j) Employer-sponsored self-funded health plans;
39 (k) Dental only and vision only coverage;

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

8 (m) Civilian health and medical program for the veterans affairs
9 administration (CHAMPVA); and

10 (n) Coverage supplemental to the coverage provided under an
11 employer or union-sponsored prescription drug coverage that
12 supplements medicare part D coverage provided through an employer
13 group waiver plan under 42 C.F.R. Sec. 423.458(c) of the social
14 security act and chapter 12 of the medicare prescription drug benefit
15 manual.

16 (30) "Individual market" means the market for health insurance
17 coverage offered to individuals other than in connection with a group
18 health plan.

19 (31) "In-network" or "participating" means a provider or facility
20 that has contracted with a carrier or a carrier's contractor or
21 subcontractor to provide health care services to enrollees and be
22 reimbursed by the carrier at a contracted rate as payment in full for
23 the health care services, including applicable cost-sharing
24 obligations.

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

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

33 (34) "Out-of-network" or "nonparticipating" means a provider or
34 facility that has not contracted with a carrier or a carrier's
35 contractor or subcontractor to provide health care services to
36 enrollees.

37 (35) "Out-of-pocket maximum" or "maximum out-of-pocket" means the
38 maximum amount an enrollee is required to pay in the form of cost-
39 sharing for covered benefits in a plan year, after which the carrier

1 covers the entirety of the allowed amount of covered benefits under
2 the contract of coverage.

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

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

13 (38) (a) "Protected individual" means:

14 (i) An adult covered as a dependent on the enrollee's health
15 benefit plan, including an individual enrolled on the health benefit
16 plan of the individual's registered domestic partner; or

17 (ii) A minor who may obtain health care without the consent of a
18 parent or legal guardian, pursuant to state or federal law.

19 (b) "Protected individual" does not include an individual deemed
20 not competent to provide informed consent for care under RCW
21 11.88.010(1)(e).

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

28 (40) "Sensitive health care services" means health services
29 related to reproductive health, sexually transmitted diseases,
30 substance use disorder, gender dysphoria, gender affirming care,
31 domestic violence, and mental health.

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

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

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

29 (43) "Standard health questionnaire" means the standard health
30 questionnaire designated under chapter 48.41 RCW.

31 (44) "Surgical or ancillary services" means surgery,
32 anesthesiology, pathology, radiology, laboratory, or hospitalist
33 services.

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

39 (46) "Wellness activity" means an explicit program of an activity
40 consistent with department of health guidelines, such as, smoking

1 cessation, injury and accident prevention, reduction of alcohol
2 misuse, appropriate weight reduction, exercise, automobile and
3 motorcycle safety, blood cholesterol reduction, and nutrition
4 education for the purpose of improving enrollee health status and
5 reducing health service costs.

6 **Sec. 2.** RCW 48.43.733 and 2016 c 156 s 2 are each amended to
7 read as follows:

8 (1) All rates and forms of group health benefit plans other than
9 small group plans, and all stand-alone dental (~~and all~~) plans,
10 stand-alone vision plans, and stand-alone prescription drug coverage
11 that supplements medicare part D coverage provided through an
12 employer group waiver plan under 42 C.F.R. Sec. 423.458(c) of the
13 social security act, offered by a health carrier or limited health
14 care service contractor as defined in RCW 48.44.035 and modification
15 of a contract form or rate must be filed before the contract form is
16 offered for sale to the public and before the rate schedule is used.

17 (2) Filings of negotiated health benefit plans, stand-alone
18 dental(~~7~~) and stand-alone vision contract forms, and stand-alone
19 prescription drug coverage forms that supplement medicare part D
20 coverage provided through an employer group waiver plan, for groups
21 other than small groups, and applicable rate schedules, that are
22 placed into effect at time of negotiation or that have a retroactive
23 effective date are not required to be filed in accordance with
24 subsection (1) of this section, but must be filed within thirty
25 working days after the earlier of:

26 (a) The date group contract negotiations are completed; or

27 (b) The date renewal premiums are implemented.

28 (3) For purposes of this section, a negotiated contract form is a
29 health benefit plan, stand-alone dental plan, or stand-alone vision
30 plan where benefits, and other terms and conditions, including the
31 applicable rate schedules are negotiated and agreed to by the carrier
32 or limited health care service contractor and the policy or contract
33 holder. The negotiated policy form and associated rate schedule must
34 otherwise comply with state and federal laws governing the content
35 and schedule of rates for the negotiated plans.

36 (4) Stand-alone dental and stand-alone vision plans offered by a
37 disability insurer to out-of-state groups specified by RCW
38 48.21.010(2) may be negotiated, but may not be offered in this state
39 before the commissioner finds that the stand-alone dental or stand-

1 alone vision plan otherwise meets the standards set forth in RCW
2 48.21.010(2) (a) and (b).

3 (5) The commissioner may, subject to a carrier's or limited
4 health care service contractor's right to demand and receive a
5 hearing under chapters 48.04 and 34.05 RCW, disapprove filings
6 submitted under this section, as permitted under RCW 48.18.110,
7 48.44.020, and 48.46.060.

8 (6) The commissioner shall amend existing rules to standardize
9 the rate and form filing process as well as regulatory review
10 standards for the rates and forms of the plans submitted under this
11 section. The commissioner may amend the rules previously adopted
12 under (~~RCW 48.43.733~~) this section and shall amend any additional
13 rating requirements established by existing rule, that are not
14 applied to health care service contractors and health maintenance
15 organizations.

16 (7) The requirements of this section apply to (~~all~~):

17 (a) All group health benefit plans other than small group plans,
18 all stand-alone dental plans, and all stand-alone vision plans issued
19 or renewed on or after March 31, 2016; and

20 (b) All group coverage supplemental to the coverage provided
21 under an employer or union-sponsored prescription drug coverage that
22 supplements medicare part D coverage provided through an employer
23 group waiver plan under section 42 C.F.R. Sec. 423.458(c) of the
24 social security act and chapter 12 of the medicare prescription drug
25 benefit manual issued or renewed on or after July 1, 2020.

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