H-0288.1

HOUSE BILL 1207

State of Washington 60th Legislature 2007 Regular Session

By Representatives Chase, Kirby and Green

Read first time 01/15/2007. Referred to Committee on Health Care & Wellness.

AN ACT Relating to health benefit plan rates; amending RCW 48.18.110, 48.44.020, and 48.46.060; adding a new section to chapter 48.43 RCW; and repealing RCW 48.20.025, 48.44.017, and 48.46.062.

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

Sec. 1. RCW 48.18.110 and 2000 c 79 s 2 are each amended to read as follows:

(1) The commissioner shall disapprove any such form of policy, application, rider, or endorsement, or withdraw any previous approval thereof, only:

(a) If it is in any respect in violation of or does not comply with this code or any applicable order or regulation of the commissioner issued pursuant to the code; or

(b) If it does not comply with any controlling filing theretofore made and approved; or

(c) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; or

(d) If it has any title, heading, or other indication of its provisions which is misleading; or

(e) If purchase of insurance thereunder is being solicited by deceptive advertising.

(2) In addition to the grounds for disapproval of any such form as provided in subsection (1) of this section, the commissioner may disapprove any form of disability insurance policy((~~, except an individual health benefit plan,~~)) if the benefits provided therein are unreasonable in relation to the premium charged. Rates, or any modification of rates, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner.

Sec. 2. RCW 48.44.020 and 2000 c 79 s 28 are each amended to read as follows:

(1) Any health care service contractor may enter into contracts 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 such health care service contractor providing one or more health care services to such persons and such activity shall not be subject to the laws relating to insurance if the health care services are rendered by the health care service contractor or by a participating provider.

(2) The commissioner may on examination, subject to the right of the health care service contractor to demand and receive a hearing under chapters 48.04 and 34.05 RCW, disapprove any individual or group contract form for any of the following grounds:

(a) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; or

(b) If it has any title, heading, or other indication of its provisions which is misleading; or

(c) If purchase of health care services thereunder is being solicited by deceptive advertising; or

(d) If it contains unreasonable restrictions on the treatment of patients; or

(e) If it violates any provision of this chapter; or

(f) If it fails to conform to minimum provisions or standards required by regulation made by the commissioner pursuant to chapter 34.05 RCW; or

(g) If any contract 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.

(3) In addition to the grounds listed in subsection (2) of this section, the commissioner may disapprove any ((~~group~~)) contract if the benefits provided therein are unreasonable in relation to the amount charged for the contract. Rates, or any modification of rates, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner.

(4)(a) Every contract between a health care service contractor and a participating provider of health care services shall be in writing and shall state that in the event the health care service contractor fails to pay for health care services as provided in the contract, the enrolled participant shall not be liable to the provider for sums owed by the health care service contractor. Every such contract shall provide that this requirement shall survive termination of the contract.

(b) No participating provider, agent, trustee, or assignee may maintain any action against an enrolled participant to collect sums owed by the health care service contractor.

Sec. 3. RCW 48.46.060 and 2000 c 79 s 31 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) Subject to the right of the health maintenance organization to demand and receive a hearing 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) In addition to the grounds listed in subsection (2) of this section, the commissioner may disapprove any ((~~group~~)) agreement if the benefits provided therein are unreasonable in relation to the amount charged for the agreement. Rates, or any modification of rates, for individual health benefit plans may not be used until sixty days after they are filed with the commissioner.

(5) 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) No agreement form or amendment to an approved agreement form shall be used unless it is first filed with the commissioner.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

(1) The commissioner must take into consideration the surplus of the carrier when reviewing a carrier's rate under this title.

(2) By July 1, 2008, the commissioner must adopt rules setting standards for taking into consideration a carrier's surplus when reviewing rate filings.

NEW SECTION. **Sec. 5.** The following acts or parts of acts are each repealed:

(1) RCW 48.20.025 (Schedule of rates for individual health benefit plans--Loss ratio--Remittance of premiums--Definitions) and 2003 c 248 s 8, 2001 c 196 s 1, & 2000 c 79 s 3;

(2) RCW 48.44.017 (Schedule of rates for individual contracts--Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 11 & 2000 c 79 s 29; and

(3) RCW 48.46.062 (Schedule of rates for individual agreements--Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 12 & 2000 c 79 s 32.

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