S-3693.2

SENATE BILL 6607

State of Washington **61st Legislature** **2010 Regular Session**

By Senators Hobbs, Pflug, and Keiser

Read first time 01/19/10. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to premium changes and annual deductible periods
2 for individual health coverage; amending RCW 48.44.022, 48.46.063, and
3 48.20.028; reenacting and amending RCW 48.43.005; and creating new
4 sections.

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

6 NEW SECTION. **Sec. 1.** The legislature recognizes that it is
7 confusing for individuals to receive annual premium changes midyear
8 while annual deductible periods are on a calendar year basis. It is
9 the intent of the legislature that individuals purchasing insurance
10 have the opportunity to understand what they are purchasing, and that
11 annual premium changes and annual deductible periods coincide where
12 possible to ensure individuals have the fewest possible changes in
13 their health plans.

14 **Sec. 2.** RCW 48.44.022 and 2006 c 100 s 3 are each amended to read
15 as follows:
16 (1) Except for health benefit plans covered under RCW 48.44.021,
17 premium rates for health benefit plans for individuals shall be subject
18 to the following provisions:

(a) The health care service contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health care service contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) <u>The annual premium change and the annual deductible period must be aligned.</u>

<u>(h)</u> For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network

providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

((~~(h)~~)) (i) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.44.021, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.44.023.

(3) As used in this section and RCW 48.44.023 "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 3. RCW 48.46.063 and 2006 c 100 s 6 are each amended to read as follows:

(1) Premiums for health benefit plans for individuals who purchase the plan as a member of a purchasing pool:

(a) Consisting of five hundred or more individuals affiliated with a particular industry;

(b) To whom care management services are provided as a benefit of pool membership; and

(c) Which allows contributions from more than one employer to be used towards the purchase of an individual's health benefit plan;

shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. Such rates are subject to the following provisions:

(i) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(A) Geographic area;

(B) Family size;

(C) Age;

(D) Tenure discounts; and

(E) Wellness activities.

(ii) The adjustment for age in (c)(i)(C) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(iii) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer, and coverage for which medicare is not the primary payer. Both rates are subject to the requirements of this subsection.

(iv) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(v) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(vi) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(A) Changes to the family composition;

(B) Changes to the health benefit plan requested by the individual; or

(C) Changes in government requirements affecting the health benefit plan.

(vii) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(viii) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(ix) The annual premium change and the annual deductible period must be aligned.

(2) Adjusted community rates established under this section shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066.

1 (3) As used in this section and RCW 48.46.066, "health benefit
2 plan," "adjusted community rates," "small employer," and "wellness
3 activities" mean the same as defined in RCW 48.43.005.

4 **Sec. 4.** RCW 48.20.028 and 2006 c 100 s 1 are each amended to read
5 as follows:
6 (1) Premiums for health benefit plans for individuals shall be
7 calculated using the adjusted community rating method that spreads
8 financial risk across the carrier's entire individual product
9 population, except the individual product population covered under RCW
10 48.20.029. All such rates shall conform to the following:
11 (a) The insurer shall develop its rates based on an adjusted
12 community rate and may only vary the adjusted community rate for:
13 (i) Geographic area;
14 (ii) Family size;
15 (iii) Age;
16 (iv) Tenure discounts; and
17 (v) Wellness activities.
18 (b) The adjustment for age in (a)(iii) of this subsection may not
19 use age brackets smaller than five-year increments which shall begin
20 with age twenty and end with age sixty-five. Individuals under the age
21 of twenty shall be treated as those age twenty.
22 (c) The insurer shall be permitted to develop separate rates for
23 individuals age sixty-five or older for coverage for which medicare is
24 the primary payer and coverage for which medicare is not the primary
25 payer. Both rates shall be subject to the requirements of this
26 subsection.
27 (d) The permitted rates for any age group shall be no more than
28 four hundred twenty-five percent of the lowest rate for all age groups
29 on January 1, 1996, four hundred percent on January 1, 1997, and three
30 hundred seventy-five percent on January 1, 2000, and thereafter.
31 (e) A discount for wellness activities shall be permitted to
32 reflect actuarially justified differences in utilization or cost
33 attributed to such programs not to exceed twenty percent.
34 (f) The rate charged for a health benefit plan offered under this
35 section may not be adjusted more frequently than annually except that
36 the premium may be changed to reflect:
37 (i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) The annual premium change and the annual deductible period must be aligned.

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

((~~(h)~~)) (i) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.20.029, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045.

(3) As used in this section, "health benefit plan," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

(4) This section shall not apply to premiums for health benefit plans covered under RCW 48.20.029.

Sec. 5. RCW 48.43.005 and 2008 c 145 s 20 and 2008 c 144 s 1 are each reenacted and amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

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

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

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

((~~In July 2008, and in each July thereafter,~~)) The insurance commissioner shall annually adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for a preceding twelve months, as determined by the United States department of labor. The adjusted amount shall apply ((~~on the following January 1st~~)) to the next annual deductible period.

(6) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness,

1 level of care, or effectiveness under the auspices of the applicable
2 health benefit plan.

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

5 (8) "Covered person" or "enrollee" means a person covered by a
6 health plan including an enrollee, subscriber, policyholder,
7 beneficiary of a group plan, or individual covered by any other health
8 plan.

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

12 (10) "Employee" has the same meaning given to the term, as of
13 January 1, 2008, under section 3(6) of the federal employee retirement
14 income security act of 1974.

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

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

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

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

37 (15) "Health care facility" or "facility" means hospices licensed
38 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,

rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

(f) Coverage incidental to a property/casualty liability insurance

policy such as automobile personal injury protection coverage and homeowner guest medical;

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

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

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

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

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

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least two but no more than

fifty employees, during the previous calendar year and employed at least two employees on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

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

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

NEW SECTION. **Sec. 6.** The insurance commissioner may adopt rules to implement this act.

NEW SECTION. **Sec. 7.** This act applies to all policies issued or renewed on or after January 1, 2011.

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