S-3840.2

SENATE BILL 6670

State of Washington 61st Legislature 2010 Regular Session

By Senator Parlette

Read first time 01/20/10. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to group medical insurance for nontraditional groups; amending RCW 48.21.010, 48.21.030, 48.44.010, and 48.46.020; adding a new section to chapter 48.43 RCW; and creating new sections.

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

NEW SECTION. **Sec. 1.** It is the intent of the legislature to allow the office of insurance commissioner to recognize nontraditional groups and allow these groups to purchase group medical insurance. Current group purchases are limited to such groups as employers, trade associations, and labor unions. The legislature recognizes that additional groups of individuals, such as church congregants or bank depositors, may benefit from the opportunity to purchase insurance together and it is the desire of the legislature that opportunities to purchase insurance be expanded.

Sec. 2. RCW 48.21.010 and 1992 c 226 s 2 are each amended to read as follows:

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 shall also include such other groups as qualify for group life insurance under the provisions of this code. The commissioner may also recognize nontraditional groups not meeting the group definitions provided in this chapter for purposes of purchasing group medical coverage, pursuant to section 4 of this act.

Sec. 3. RCW 48.21.030 and 1947 c 79 s .21.03 are each amended to read as follows:

(1) A policy of group disability insurance may be issued to a corporation, as policyholder, existing primarily for the purpose of assisting individuals who are its subscribers in securing medical, hospital, dental, and other health care services for themselves and their dependents, covering all and not less than five hundred such subscribers and dependents, with respect only to medical, hospital, dental, and other health care services.

(2) A policy of group disability insurance may be issued to a nontraditional group if the commissioner finds that: (a) The issuance of the policy is not contrary to the best interest of the public; (b) the issuance of the policy would result in economies of acquisition or administration; and (c) the benefits are reasonable in relation to the premiums charged. The commissioner may allow policies sold in this state or policies issued in another state.

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

Group health insurance coverage offered to a resident of this state or in connection with employment within this state under a group health insurance policy issued to a nontraditional group as defined in subsection (3) of this section shall be subject to the following requirements:

(1) For any such coverage to be delivered in this state the commissioner must find that:

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

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

(c) The benefits are reasonable in relation to the premiums charged.

(2) For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner in this state or the state in which the policy is issued, having requirements substantially similar to those contained in subsection (1) of this section, must make a determination that the requirements of subsection (1) of this section have been met.

(3) For purposes of this section, a "nontraditional group" is an employer or group other than an employer or group that purchases benefits subject to the federal health insurance portability and accountability act of 1996 or that is otherwise defined in this chapter as an eligible group.

Sec. 5. RCW 48.44.010 and 2007 c 267 s 2 are each amended to read as follows:

For the purposes of this chapter:

(1) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

(2) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes health care services and is licensed to furnish such services.

(3) "Health care service contractor" means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services. "Health care service contractor" does not include direct patient-provider primary care practices as defined in RCW 48.150.010.

(4) "Participating provider" means a provider, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services.

(5) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health care service contractor to receive health care services.

(6) "Commissioner" means the insurance commissioner.

(7) "Uncovered expenditures" means the costs to the health care service contractor for health care services that are the obligation of the health care service contractor for which an enrolled participant would also be liable in the event of the health care service contractor's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health care service contractor, or for services that are guaranteed, insured or assumed by a person or organization other than the health care service contractor.

(8) "Copayment" means an amount specified in a group or individual contract which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(9) "Deductible" means the amount an enrolled participant is responsible to pay before the health care service contractor begins to pay the costs associated with treatment.

(10) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(11) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

(12) "Carrier" means a health maintenance organization, an insurer, a health care service contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual contract.

(13) "Replacement coverage" means the benefits provided by a succeeding carrier.

(14) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(15) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.44.037(3) and are recorded as equity.

(16) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(17) "Nontraditional group" is an employer or group that is not (a) an employer or group that purchases benefits subject to the federal health insurance portability and accountability act of 1996 or (b) otherwise defined in this chapter as an eligible group. A nontraditional group may purchase group medical coverage pursuant to section 4 of this act.

Sec. 6. RCW 48.46.020 and 1990 c 119 s 1 are each amended to read as follows:

As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Health maintenance organization" means any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(2) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(3) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(4) "Health professionals" means health care practitioners who are regulated by the state of Washington.

(5) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(6) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or shareholders of stock corporations licensed as health maintenance organizations.

(7) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(8) "Meaningful grievance procedure" means a procedure for investigation of consumer grievances in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures.

(9) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes any health care services and is licensed or otherwise authorized to furnish such services.

(10) "Department" means the state department of social and health services.

(11) "Commissioner" means the insurance commissioner.

(12) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

(13) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

(14) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization.

(15) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(16) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(17) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.46.235(3) and are recorded as equity.

(18) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(19) "Participating provider" means a provider as defined in subsection (9) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or

deductible, directly or indirectly, from the health maintenance organization.

(20) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual agreement.

(21) "Replacement coverage" means the benefits provided by a succeeding carrier.

(22) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(23) "Nontraditional group" is an employer or group that is not (a) an employer or group that purchases benefits subject to the federal health insurance portability and accountability act of 1996 or (b) otherwise defined in this chapter as an eligible group. A nontraditional group may purchase group medical coverage pursuant to section 4 of this act.

NEW SECTION. **Sec. 7.** The commissioner may adopt rules to implement this act.

NEW SECTION. **Sec. 8.** This act applies to policies issued on or after January 1, 2011.

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