S-3765.1

SENATE BILL 6510

State of Washington 65th Legislature 2018 Regular Session

By Senators Short, Kuderer, Rivers, Conway, and Keiser

Read first time 01/22/18. Referred to Committee on Health & Long Term Care.

1 AN ACT Relating to benefit managers; amending RCW 48.43.005; 2 adding new sections to chapter 48.43 RCW; adding a new section to 3 chapter 19.340 RCW; adding a new section to chapter 19.365 RCW; 4 adding a new section to chapter 48.02 RCW; and providing an effective 5 date.

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

7 **Sec. 1.** RCW 48.43.005 and 2016 c 65 s 2 are each amended to read 8 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) "Applicant" means a person who applies for enrollment in an
8 individual health plan as the subscriber or an enrollee, or the
9 dependent or spouse of a subscriber or enrollee.
10 (4) "Basic health plan" means the plan described under chapter
11 70.47 RCW, as revised from time to time.
12 (5) "Basic health plan model plan" means a health plan as
13 required in RCW 70.47.060(2)(e).
14 (6) "Basic health plan services" means that schedule of covered
15 health services, including the description of how those benefits are
16 to be administered, that are required to be delivered to an enrollee
17 under the basic health plan, as revised from time to time.
18 (7) "Board" means the governing board of the Washington health
19 benefit exchange established in chapter 43.71 RCW.
20 (8)(a) For grandfathered health benefit plans issued before
21 January 1, 2014, and renewed thereafter, "catastrophic health plan"
22 means:
23 (i) In the case of a contract, agreement, or policy covering a
24 single enrollee, a health benefit plan requiring a calendar year
25 deductible of, at a minimum, one thousand seven hundred fifty dollars
26 and an annual out-of-pocket expense required to be paid under the
27 plan (other than for premiums) for covered benefits of at least three
28 thousand five hundred dollars, both amounts to be adjusted annually
29 by the insurance commissioner; and
30 (ii) In the case of a contract, agreement, or policy covering
31 more than one enrollee, a health benefit plan requiring a calendar
32 year deductible of, at a minimum, three thousand five hundred dollars
33 and an annual out-of-pocket expense required to be paid under the
34 plan (other than for premiums) for covered benefits of at least six
35 thousand dollars, both amounts to be adjusted annually by the
36 insurance commissioner.
37 (b) In July 2008, and in each July thereafter, the insurance
38 commissioner shall adjust the minimum deductible and out-of-pocket
39 expense required for a plan to qualify as a catastrophic plan to
40 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. For a plan year beginning in 2014, the out-of-pocket limits must be adjusted as specified in section 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount shall apply on the following January 1st.

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

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

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

(9) "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, level of care, or effectiveness under the auspices of the applicable health benefit plan.

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

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

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

(13) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

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

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

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

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

(18) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

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

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

(21) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care,

waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(22) "Health care facility" or "facility" means hospices licensed 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.

(23) "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.

(24) "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.

(25) "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, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

(26) "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;

1 (c) Coverage supplemental to the coverage provided under chapter
2 55, Title 10, United States Code;
3 (d) Limited health care services offered by limited health care
4 service contractors in accordance with RCW 48.44.035;
5 (e) Disability income;
6 (f) Coverage incidental to a property/casualty liability
7 insurance policy such as automobile personal injury protection
8 coverage and homeowner guest medical;
9 (g) Workers' compensation coverage;
10 (h) Accident only coverage;
11 (i) Specified disease or illness-triggered fixed payment
12 insurance, hospital confinement fixed payment insurance, or other
13 fixed payment insurance offered as an independent, noncoordinated
14 benefit;
15 (j) Employer-sponsored self-funded health plans;
16 (k) Dental only and vision only coverage;
17 (l) Plans deemed by the insurance commissioner to have a short-
18 term limited purpose or duration, or to be a student-only plan that
19 is guaranteed renewable while the covered person is enrolled as a
20 regular full-time undergraduate or graduate student at an accredited
21 higher education institution, after a written request for such
22 classification by the carrier and subsequent written approval by the
23 insurance commissioner; and
24 (m) Civilian health and medical program for the veterans affairs
25 administration (CHAMPVA).
26 (27) "Individual market" means the market for health insurance
27 coverage offered to individuals other than in connection with a group
28 health plan.
29 (28) "Material modification" means a change in the actuarial
30 value of the health plan as modified of more than five percent but
31 less than fifteen percent.
32 (29) "Open enrollment" means a period of time as defined in rule
33 to be held at the same time each year, during which applicants may
34 enroll in a carrier's individual health benefit plan without being
35 subject to health screening or otherwise required to provide evidence
36 of insurability as a condition for enrollment.
37 (30) "Preexisting condition" means any medical condition,
38 illness, or injury that existed any time prior to the effective date
39 of coverage.

(31) "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.

(32) "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.

(33) "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 one but no more than fifty employees, during the previous calendar year and employed at least one employee 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 must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one

percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

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

(35) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(36) "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.

(37) "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.

(38)(a) "Health care benefit manager" or "health benefit manager" means a person or organization providing services to or on behalf of a health carrier that relate to utilization of or benefits for health care services including, but not limited to:

(i) Prior authorization or preauthorization of benefits or care;

(ii) Precertification of benefits or care;

(iii) Postservice reviews of care;

(iv) Medical necessity reviews;

(v) Benefit determinations;

(vi) Claims processing and repricing; and

(vii) Provider and facility credentialing and recredentialing.

(b) "Health care service benefit manager" or "health benefit manager" do not include a pharmacy benefit manager as defined in RCW 19.340.010, a radiology benefit manager as defined in RCW 19.365.010 or an employee of a health carrier administering coverage for its own

plan beneficiaries under a health plan filed by the carrier with the insurance commissioner.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) To conduct business in this state, a health benefit manager must register with the office of the insurance commissioner and annually renew the registration.

(2) To register, a health benefit manager must:

(a) Submit an application in a form prescribed by the commissioner and verified by the applicant that contains at least the following information:

(i) The identity of the health benefit manager and, if an organization, of persons with an ownership or controlling interest in the health benefit manager organization including relevant business licenses and tax identification numbers;

(ii) The business name, address, phone number, and contact person for the health benefit manager; and

(iii) Such other information as the commissioner may reasonably require.

(b) Pay an initial registration fee and annual renewal registration fees established in rule by the commissioner. The fees must be set in an amount to cover the commissioner's costs in registering, renewing, and overseeing the activities of health benefit managers.

(3) All receipts from fees collected by the commissioner under this section must be deposited into the commissioner's regulatory account created in RCW 48.02.190.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Every health benefit manager must file with the commissioner, thirty days prior to use, all contracts and amendments to such contracts, executed between the health benefit manager and health carrier.

(2) Benefit manager contracts filed with the commissioner must be made available to the public on the commissioner's web site.

(3) Benefit manager compensation provisions under contracts filed with the commissioner are confidential and not subject to public inspection under RCW 48.02.120(2), or public disclosure under chapter

42.56 RCW, if filed in accordance with commissioner procedures for submitting confidential filings. Notwithstanding these nondisclosure of compensation provisions, any contract incentive or other method or formula for compensation that may affect health benefit manager decisions relating to plan benefits for or utilization of health care services shall be publicly disclosed and shall be summarized by the commissioner in a manner that balances the confidentiality of compensation provisions and the public interest in disclosure of agreements that directly or indirectly affect health plan benefits and access to health care.

(4) Upon receipt of any inquiry from the commissioner, every health benefit manager must furnish the commissioner with an adequate response to the inquiry, including but not limited to providing a statement or testimony, producing its accounts, records, and files, response to complaints, or responses to surveys and general requests within the time and in the form required by the commissioner.

(5) Subject to chapter 48.04 RCW, if the commissioner finds that a health benefit manager or any person responsible for the conduct of the health benefit manager's affairs, has violated any insurance law, or violated any rule, subpoena, or order of the commissioner; or provided incorrect, misleading, incomplete, or materially untrue information to the commissioner, to a carrier, or to a health plan beneficiary, the commissioner may, in any combination below:

(a) Place on probation, suspend, revoke, or refuse to issue or renew the health benefit manager's registration;

(b) Issue a cease and desist order against the benefit manager;

(c) Fine the health benefit manager up to five thousand dollars per violation;

(d) Issue an order against the health benefit manager, or a carrier contracting with the health benefit manager, or both, requiring corrective action; or

(e) Charge the health benefit manager for the costs, fees, and other expenses incurred by the commissioner in the conduct of any investigation, hearing, or court proceeding involving the health benefit manager.

NEW SECTION. **Sec. 4.** A new section is added to chapter 19.340 RCW to read as follows:

(1) Pharmacy benefit managers must file with the commissioner, thirty days prior to use, all contracts and amendments to such

contracts, executed between the pharmacy benefit manager and an insurer or third-party payor.

(2) Pharmacy benefit manager contracts filed with the commissioner must be made available to the public on the commissioner's web site.

(3) Pharmacy benefit manager compensation provisions under contracts filed with the commissioner are confidential and not subject to public inspection under RCW 48.02.120(2), or public disclosure under chapter 42.56 RCW, if filed in accordance with commissioner procedures for submitting confidential filings. Notwithstanding these nondisclosure of compensation provisions, any contract incentive or other method or formula for compensation that may affect benefit manager decisions relating to claims for drugs or medical supplies shall be publicly disclosed and shall be summarized by the commissioner in a manner that balances the confidentiality of compensation provisions and the public interest in disclosure of agreements that directly or indirectly affect health plan benefits and access to drugs and medical supplies.

(4) Upon receipt of any inquiry from the commissioner, every pharmacy benefit manager must furnish the commissioner with an adequate response to the inquiry, including but not limited to providing a statement or testimony, producing its accounts, records and files, response to complaints, or responses to surveys and general requests within the time and in the form required by the commissioner.

NEW SECTION. **Sec. 5.** A new section is added to chapter 19.365 RCW to read as follows:

(1) Radiology benefit managers must file with the Washington office of the insurance commissioner, thirty days prior to use, all contracts and amendments to such contracts executed between the radiology benefit manager and an insurer or third-party payor.

(2) Radiology benefit manager contracts filed with the commissioner must be made available to the public on the commissioner's web site.

(3) Radiology benefit manager compensation provisions under contracts filed with the commissioner are confidential and not subject to public inspection under RCW 48.02.120(2), or public disclosure under chapter 42.56 RCW, if filed in accordance with commissioner procedures for submitting confidential filings.

1 Notwithstanding these nondisclosure of compensation provisions, any
2 contract incentive or other method and formula for compensation that
3 may affect benefit manager decisions relating to benefits for and
4 utilization of radiology or diagnostic imaging shall be publicly
5 disclosed and shall be summarized by the commissioner in a manner
6 that balances the confidentiality of compensation provisions and the
7 public interest in disclosure of agreements that directly or
8 indirectly affect health plan benefits and access to radiology and
9 diagnostic imaging.
10 (4) Upon receipt of any inquiry from the commissioner, every
11 radiology benefit manager must furnish the commissioner with an
12 adequate response to the inquiry, including but not limited to
13 providing a statement or testimony, producing its accounts, records
14 and files, response to complaints, or responses to surveys and
15 general requests within the time and in the form required by the
16 commissioner.

17 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.02
18 RCW to read as follows:
19 The commissioner may adopt rules to implement and administer this
20 act.

21 NEW SECTION. **Sec. 7.** If any provision of this act or its
22 application to any person or circumstance is held invalid, the
23 remainder of the act or the application of the provision to other
24 persons or circumstances is not affected.

25 NEW SECTION. **Sec. 8.** This act takes effect July 1, 2018.

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