CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1233

Chapter 296, Laws of 2007

60th Legislature
2007 Regular Session

FIXED PAYMENT INSURANCE

EFFECTIVE DATE: 07/22/07

Passed by the House April 14, 2007
Yeas 94 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate April 5, 2007
Yeas 47 Nays 0

BRAD OWEN

President of the Senate

Approved May 2, 2007, 3:19 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1233** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

Chief Clerk

FILED

May 3, 2007

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1233

AS AMENDED BY THE SENATE

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By House Committee on Health Care & Wellness (originally sponsored by Representatives Ericks, Kirby, Roach, Williams, Jarrett and Simpson)

READ FIRST TIME 02/12/07.

AN ACT Relating to specified disease, hospital confinement, or other fixed payment insurance; amending RCW 48.43.005; adding new sections to chapter 48.20 RCW; adding new sections to chapter 48.21 RCW; and adding a new section to chapter 48.43 RCW.

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

Sec. 1. RCW 48.43.005 and 2006 c 25 s 16 are each 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 deductible of, at a minimum, one 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 three thousand dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand 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 five thousand five hundred dollars; 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.

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

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

(8) "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.

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

(10) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term

includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

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

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

(13) "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.

(14) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) 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.

(15) "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.

(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 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 ((~~and~~)) or illness-triggered fixed payment insurance, hospital confinement ((~~indemnity when marketed solely as a supplement to a health plan~~)) 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, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and 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 eligible 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 must derive 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 for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive 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. 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. 2.** A new section is added to chapter 48.20 RCW to read as follows:

The commissioner shall adopt rules setting forth the content of a standard disclosure form to be provided to all applicants for individual, illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. The standard disclosure shall provide information regarding the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions under the policy, as well as additional information to enhance consumer understanding. The disclosure shall specifically disclose that the coverage is not comprehensive in nature and will not cover the cost of most hospital and other medical services. Such disclosure form must be filed for approval with the commissioner prior to use. The standard disclosure forms must be provided at the time of solicitation and completion of the application form. All advertising and marketing materials other than the standard disclosure form must be filed with the commissioner at least thirty days prior to use.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.20 RCW to read as follows:

Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance policies are not considered to provide coverage for hospital or medical expenses under this chapter, if the benefits provided are a fixed dollar amount that is paid regardless of the amount charged. The benefits may not be related to, or be a percentage of, the amount charged by the provider of service and must be offered as an independent and noncoordinated benefit with any other health plan as defined in RCW 48.43.005(19).

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.21 RCW to read as follows:

The commissioner shall adopt rules setting forth the content of a standard disclosure form to be delivered to all applicants for group illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. The standard disclosure shall provide information regarding the level, type, and amount of benefits provided and the limitations, exclusions, and exceptions under the policy, as well as additional information to

enhance consumer understanding. The disclosure shall specifically disclose that the coverage is not comprehensive in nature and will not cover the cost of most hospital and other medical services. Such disclosure form must be filed for approval with the commissioner prior to use. The standard disclosure form must be provided to the master policyholders at the time of solicitation and completion of the application and to all enrollees at the time of enrollment. All advertising and marketing materials other than the standard disclosure form must be filed with the commissioner at least thirty days prior to use.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.21 RCW to read as follows:

Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance policies are not considered to provide coverage for hospital or medical expenses or care under this chapter, if the benefits provided are a fixed dollar amount that is paid regardless of the amount charged. The benefits may not be related to, or be a percentage of, the amount charged by the provider of service and must be offered as an independent and noncoordinated benefit with any other health plan as defined in RCW 48.43.005(19).

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW to read as follows:

The commissioner shall collect information from insurers offering fixed payment insurance products, and report aggregated data for each calendar year, including the number of groups purchasing the products, the number of enrollees, and the number of consumer complaints filed. The reports shall be provided to the legislature annually to reflect the calendar year experience, and the initial report shall reflect calendar year 2008 and be due no later than June 1, 2009, and each June thereafter.

Passed by the House April 14, 2007.
Passed by the Senate April 5, 2007.
Approved by the Governor May 2, 2007.
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