5521-S AMH HC H2669.1

SSB 5521 - H COMM AMD
By Committee on Health Care

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 48.21.045 and 1995 c 265 s 14 are each amended to read as follows:

(1)(a) By January 1, 2004, an insurer offering any health benefit plan to a small employer shall offer and actively market to the small employer a single health benefit plan ((~~providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan~~)) featuring a limited schedule of covered health services. Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more ((~~or less~~)) comprehensive benefits than ((~~the basic health plan, provided such plans are in accordance with this chapter~~)) those included in the product offered under this subsection. Any health benefit plan offered by an insurer in addition to the plan offered under this subsection is subject to all requirements applicable to health benefit plans offered under this chapter. An insurer offering a health benefit plan ((~~that does not include benefits in the basic health plan~~)) under this subsection shall clearly disclose ((~~these differences~~)) all covered benefits to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter ((~~18.57 or 18.71 RCW but~~)) 18.22, 18.57, or 18.71 RCW, a naturopath licensed under chapter 18.36A RCW, or a nurse licensed under chapter 18.79 RCW. The insurer may require that persons covered under this health benefit plan choose a single primary care practitioner for receipt of primary care services. The health benefit plan offered under this subsection is not subject to the

requirements of RCW 48.21.130, ((~~48.21.140, 48.21.141,~~)) 48.21.142, 48.21.144, 48.21.146, ((~~48.21.160 through 48.21.197,~~)) 48.21.200, 48.21.220, ((~~48.21.225, 48.21.230, 48.21.235,~~)) 48.21.240, 48.21.244, 48.21.250, ((~~48.21.300,~~)) 48.21.310, ((~~or~~)) 48.21.320 ((~~if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii)~~)), or 48.43.045. If a health benefit plan offered under this subsection does not adhere to the requirements of RCW 48.43.045, the plan cannot offer services that would be within the permitted scope of practice of providers whose services would be covered but for the insurer's decision not to adhere to the requirements of RCW 48.43.045. The health benefit plan ((~~is~~)) authorized in this section may be offered to employers with not more than ((~~twenty-five~~)) fifty employees.

(2) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the ((~~basic health plan services~~)) health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The insurer 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; and

(iv) 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. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer 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 (3).

(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 of the lowest rate for all age groups on January 1, 2000, and five hundred percent on January 1, 2004, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs ((~~not to exceed twenty percent~~)).

(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 enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

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

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(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.

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage.

(4) ((~~The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) Nothing

in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

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

Sec. 2. RCW 48.44.023 and 1995 c 265 s 16 are each amended to read as follows:

(1)(a) By January 1, 2004, a health care services contractor offering any health benefit plan to a small employer shall offer and

actively market to the small employer a single health benefit plan ((~~providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan~~)) featuring a limited schedule of covered health services. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more ((~~or less~~)) comprehensive benefits than ((~~the basic health plan, provided such plans are in accordance with this chapter~~)) those included in the product offered under this subsection. Any health benefit plan offered by a contractor in addition to the plan offered under this subsection is subject to all requirements applicable to health benefit plans offered under this chapter. A contractor offering a health benefit plan ((~~that does not include benefits in the basic health plan~~)) under this subsection shall clearly disclose ((~~these differences~~)) all covered benefits to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter ((~~18.57 or 18.71 RCW but~~)) 18.22, 18.57, or 18.71 RCW, a naturopath licensed under chapter 18.36A RCW, or a nurse licensed under chapter 18.79 RCW. The insurer may require that persons covered under this health benefit plan choose a single primary care practitioner for receipt of primary care services. The health benefit plan offered under this subsection is not subject to the requirements of RCW ((~~48.44.225,~~)) 48.44.240, 48.44.245, ((~~48.44.290, 48.44.300,~~)) 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, ((~~48.44.440,~~)) 48.44.450, ((~~and~~)) 48.44.460 ((~~if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii)~~)), or 48.43.045. If a health benefit plan offered under this subsection does not adhere to the requirements of RCW 48.43.045, the plan cannot offer services that would be within the permitted scope of practice of providers whose services would be covered but for the contractor's decision not to adhere to the requirements of RCW 48.43.045. The health benefit plan ((~~is~~))

authorized in this subsection may be offered to employers with not more than ((~~twenty-five~~)) fifty employees.

(2) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, health benefits plans with benefits in excess of the ((~~basic health plan services~~)) health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The 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; and

(iv) 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. Employees under the age of twenty shall be treated as those age twenty.

(c) The 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 (3).

(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 of the lowest rate for all age groups on January 1, 2000, and five hundred percent on January 1, 2004, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs ((~~not to exceed twenty percent~~)).

(f) The rate charged for a health benefit plan offered under this

1 section may not be adjusted more frequently than annually except that
2 the premium may be changed to reflect:
3 (i) Changes to the enrollment of the small employer;
4 (ii) Changes to the family composition of the employee;
5 (iii) Changes to the health benefit plan requested by the small
6 employer; or
7 (iv) Changes in government requirements affecting the health
8 benefit plan.
9 (g) Rating factors shall produce premiums for identical groups that
10 differ only by the amounts attributable to plan design, with the
11 exception of discounts for health improvement programs.
12 (h) For the purposes of this section, a health benefit plan that
13 contains a restricted network provision shall not be considered similar
14 coverage to a health benefit plan that does not contain such a
15 provision, provided that the restrictions of benefits to network
16 providers result in substantial differences in claims costs. This
17 subsection does not restrict or enhance the portability of benefits as
18 provided in RCW 48.43.015.
19 (i) Adjusted community rates established under this section shall
20 pool the medical experience of all groups purchasing coverage.
21 (4) ((~~The health benefit plans authorized by this section that are~~
22 ~~lower than the required offering shall not supplant or supersede any~~
23 ~~existing policy for the benefit of employees in this state.~~)) Nothing
24 in this section shall restrict the right of employees to collectively
25 bargain for insurance providing benefits in excess of those provided
26 herein.
27 (5)(a) Except as provided in this subsection, requirements used by
28 a contractor in determining whether to provide coverage to a small
29 employer shall be applied uniformly among all small employers applying
30 for coverage or receiving coverage from the carrier.
31 (b) A contractor shall not require a minimum participation level
32 greater than:
33 (i) One hundred percent of eligible employees working for groups
34 with three or less employees; and
35 (ii) Seventy-five percent of eligible employees working for groups
36 with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 3. RCW 48.46.066 and 1995 c 265 s 18 are each amended to read as follows:

(1)(a) Beginning January 1, 2004, a health maintenance organization offering any health benefit plan to a small employer shall offer and actively market to the small employer a single health benefit plan ((~~providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan~~)) featuring a limited schedule of covered health services. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more ((~~or less~~)) comprehensive benefits than ((~~the basic health plan, provided such plans are in accordance with this chapter~~)) those included in the product offered under this subsection. Any health benefit plan offered by a health maintenance organization in addition to the plan offered under this subsection is subject to all requirements applicable to health benefit plans offered under this chapter. A health maintenance organization offering a health benefit plan ((~~that does not include benefits in the basic health plan~~)) under this subsection shall clearly

disclose ((~~these differences~~)) all covered benefits to the small employer in a brochure approved by the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter ((~~18.57 or 18.71 RCW but~~)) 18.22, 18.57, or 18.71 RCW, a naturopath licensed under chapter 18.36A RCW, or a nurse licensed under chapter 18.79 RCW. The health maintenance organization may require that persons covered under this health benefit plan choose a single primary care practitioner for receipt of primary care services. The health benefit plan offered under this subsection is not subject to the requirements of RCW ((~~48.46.275, 48.46.280, 48.46.285,~~)) 48.46.290, ((~~48.46.350, 48.46.355,~~)) 48.46.375, 48.46.440, 48.46.480, ((~~48.46.510,~~)) 48.46.520, ((~~and~~)) 48.46.530 ((~~if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii)~~)), or 48.43.045. If a health benefit plan offered under this subsection does not adhere to the requirements of RCW 48.43.045, the plan cannot offer services that would be within the permitted scope of practice of providers whose services would be covered but for the health maintenance organization's decision not to adhere to the requirements of RCW 48.43.045. The health benefit plan ((~~is~~)) authorized in this section may be offered to employers with not more than ((~~twenty-five~~)) fifty employees.

(2) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the ((~~basic health plan services~~)) health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

(a) The health maintenance organization 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; and

(iv) 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. Employees under the age of twenty shall be treated as those age twenty.

(c) 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 shall be subject to the requirements of this subsection (3).

(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 of the lowest rate for all age groups on January 1, 2000, and five hundred percent on January 1, 2004, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs ((~~not to exceed twenty percent~~)).

(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 enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

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

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(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.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.

(4) ((~~The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(6) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or

dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 4. RCW 48.43.035 and 2000 c 79 s 24 are each amended to read as follows:

For group health benefit plans, the following shall apply:

(1) Except as provided in subsection (2) of this section, all health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) A health carrier may require any sole proprietor or self-employed individual applying for a group health benefit plan to complete the standard health questionnaire designated under chapter 48.41 RCW. The exceptions to the health benefit questionnaire requirement provided in RCW 48.43.018(1) (a) through (c) apply to applications by sole proprietors or self-employed individuals for group health benefit plans.

(a) If, based upon the results of the standard health questionnaire, the sole proprietor or self-employed individual qualifies for coverage under the Washington state health insurance pool, the following apply:

(i) The carrier may decide not to accept the sole proprietor or self-employed individual's application for enrollment in its group health benefit plan; and

(ii) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the sole proprietor or self-employed individual's

application for enrollment to both the sole proprietor or self-employed individual and the administrator of the Washington state health insurance pool. The notice to the sole proprietor or self-employed individual must state that the individual is eligible for health insurance provided by the Washington state health insurance pool, and must include information about the Washington state health insurance pool and an application for such coverage. If the carrier does not provide or postmark the notice within fifteen business days, the application is deemed approved.

(b) If the sole proprietor or self-employed individual applying for a group health benefit plan: (i) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (ii) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire and the carrier elects to accept the person for enrollment; or (iii) is not required to complete the standard health questionnaire under this subsection, the carrier shall accept the sole proprietor or self-employed individual for enrollment if he or she resides within the carrier's service area and provide or ensure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2).

(3) Except as provided in subsection ((~~(5)~~)) (6) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. The carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

((~~(3)~~)) (4) The guarantee of continuity of coverage required in health plans shall not prevent a carrier from canceling or nonrenewing a health plan for:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the insurance commissioner;

(c) Covered persons entitled to become eligible for medicare benefits by reason of age who fail to apply for a medicare supplement plan or medicare cost, risk, or other plan offered by the carrier pursuant to federal laws and regulations;

(d) Covered persons who fail to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the carrier;

(f) Covered persons who materially breach the health plan; or

(g) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

((~~(4) The provisions of~~)) (5) This section ((~~do~~)) does not apply in the following cases:

(a) A carrier has zero enrollment on a product; or

(b) For group health plans sold to groups other than small employer groups, a carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product; or

(c) For group health plans offered to small employer groups, no sooner than October 1, 2003, a carrier discontinues offering a particular type of health benefit plan if: (i) The carrier provides notice to each group provided coverage of this type of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll in any other small employer group health benefit plan currently being offered by the carrier; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of individuals enrolled through the small employer group, individuals who may become eligible for such coverage, or the collective health status of groups enrolled in coverage of this type; or

(d) A carrier discontinues offering all small employer group health coverage in the state and discontinues coverage under all existing small employer group health benefit plans if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all small employer group health coverage in the state and its intent to discontinue coverage under all existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all existing health benefit plans; and (ii) the carrier provides notice to each covered small employer group of the intent to discontinue his or her existing health benefit plan at least one hundred eighty days prior to the date of the discontinuation and includes information in the notice that can help the small employer group identify alternative sources of coverage. In the case of discontinuation under this subsection, the carrier may not issue any small employer group health coverage in this state for a five-year period beginning on the date of the discontinuation of the last health plan not so renewed. Nothing in this subsection (5) may be construed to require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants where the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

(e) A carrier is withdrawing from a service area or from a segment of its service area because the carrier has demonstrated to the insurance commissioner that the carrier's clinical, financial, or administrative capacity to serve enrollees would be exceeded.

((~~(5)~~)) (6) The provisions of this section do not apply to health plans deemed by the insurance commissioner to be unique or limited or have a short-term purpose, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43 RCW to read as follows:

Beginning January 1, 2004, any carrier offering health benefit plans to small employers in addition to the single benefit plan authorized under RCW 48.21.045(1), 48.44.023(1), and 48.46.066(1) must offer and actively market to small employers at least three other plans

of the carrier's choosing. Nothing in this section limits the ability of a carrier to offer small employer group health benefit plans subject to all requirements applicable to health benefit plans offered under this chapter in addition to those that must be offered under this section.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.21 RCW to read as follows:

(1) As used in this section, "loss ratio" means incurred claims expense as a percentage of earned premiums.

(2) By the last day of May each year any health insurer issuing or renewing small employer group health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its small employer group health benefit plans offered or renewed in this state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is received by the commissioner, the filing is deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the health insurer.

(c) Any dispute regarding the calculation of the actual loss ratio shall upon written demand of either the commissioner or the health insurer be submitted to hearing under chapters 48.04 and 34.05 RCW.

(3) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (4) of this section, a remittance is due and the following apply:

(a) The health insurer shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (4) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest must be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances must be aggregated and such amounts must be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section must be issued within thirty days after the actual loss ratio is deemed approved under subsection (2)(a) of this section or the determination by an administrative law judge under subsection (2)(c) of this section.

(4) The loss ratio applicable to this section is eighty-two percent minus the premium tax rate applicable to the health insurer's small employer group health benefit plans under RCW 48.14.0201.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.44 RCW to read as follows:

(1) As used in this section, "loss ratio" means incurred claims expense as a percentage of earned premiums.

(2) By the last day of May each year any health care service contractor issuing or renewing small employer group health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its small employer group health benefit plans offered or renewed in this state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) At the expiration of a thirty-day period beginning with the date the filing is received by the commissioner, the filing is deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio.

(b) If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the health care service contractor.

(c) Any dispute regarding the calculation of the actual loss ratio shall upon written demand of either the commissioner or the health care service contractor be submitted to hearing under chapters 48.04 and 34.05 RCW.

(3) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (4) of this section, a remittance is due and the following apply:

(a) The health care service contractor shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection (4) of this section.

(b) The remittance to the Washington state health insurance pool is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee in the previous calendar year. Interest must be added to the remittance due at a five percent annual rate calculated from the end of the calendar year for which the remittance is due to the date the remittance is made.

(c) All remittances must be aggregated and such amounts must be remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section must be issued within thirty days after the actual loss ratio is deemed approved under subsection (2)(a) of this section or the determination by an administrative law judge under subsection (2)(c) of this section.

(4) The loss ratio applicable to this section is eighty-two percent minus the premium tax rate applicable to the health care service contractor's small employer group health benefit plans under RCW 48.14.0201.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.46 RCW to read as follows:

(1) As used in this section, "loss ratio" means incurred claims expense as a percentage of earned premiums.

1 (2) By the last day of May each year any health maintenance
2 organization issuing or renewing small employer group health benefit
3 plans in this state during the preceding calendar year shall file for
4 review by the commissioner supporting documentation of its actual loss
5 ratio for its small employer group health benefit plans offered or
6 renewed in this state in aggregate for the preceding calendar year.
7 The filing shall include aggregate earned premiums, aggregate incurred
8 claims, and a certification by a member of the American academy of
9 actuaries, or other person approved by the commissioner, that the
10 actual loss ratio has been calculated in accordance with accepted
11 actuarial principles.
12 (a) At the expiration of a thirty-day period beginning with the
13 date the filing is received by the commissioner, the filing is deemed
14 approved unless prior thereto the commissioner contests the calculation
15 of the actual loss ratio.
16 (b) If the commissioner contests the calculation of the actual loss
17 ratio, the commissioner shall state in writing the grounds for
18 contesting the calculation to the health maintenance organization.
19 (c) Any dispute regarding the calculation of the actual loss ratio
20 shall upon written demand of either the commissioner or the health
21 maintenance organization be submitted to hearing under chapters 48.04
22 and 34.05 RCW.
23 (3) If the actual loss ratio for the preceding calendar year is
24 less than the loss ratio standard established in subsection (4) of this
25 section, a remittance is due and the following apply:
26 (a) The health maintenance organization shall calculate a
27 percentage of premium to be remitted to the Washington state health
28 insurance pool by subtracting the actual loss ratio for the preceding
29 year from the loss ratio established in subsection (4) of this section.
30 (b) The remittance to the Washington state health insurance pool is
31 the percentage calculated in (a) of this subsection, multiplied by the
32 premium earned from each enrollee in the previous calendar year.
33 Interest must be added to the remittance due at a five percent annual
34 rate calculated from the end of the calendar year for which the
35 remittance is due to the date the remittance is made.
36 (c) All remittances must be aggregated and such amounts must be

remitted to the Washington state high risk pool to be used as directed by the pool board of directors.

(d) Any remittance required to be issued under this section must be issued within thirty days after the actual loss ratio is deemed approved under subsection (2)(a) of this section or the determination by an administrative law judge under subsection (2)(c) of this section.

(4) The loss ratio applicable to this section is eighty-two percent minus the premium tax rate applicable to the health maintenance organization's small employer group health benefit plans under RCW 48.14.0201.

NEW SECTION. **Sec. 9.** (1) The insurance commissioner shall submit a report to the legislature by December 2006 on the extent to which the health benefits plans authorized under RCW 48.21.045(1), 48.44.023(1), and 48.46.066(1) have been marketed and sold, and the extent to which those plans are being offered by carriers that are new entrants into the small group market, and the impact of those plans, RCW 48.43.035, and section 5 of this act on the small group health insurance market.

(2) To facilitate preparation of the report required in subsection (1) of this section, each carrier shall submit the following information to the commissioner annually, beginning on a date set by the commissioner:

(a) For each small employer group health benefit plan sold in Washington state, including the health benefits plans authorized under RCW 48.21.045(1), 48.44.023(1), and 48.46.066(1):

(i) Benefits covered;

(ii) Enrollment, including the number of sole proprietors or self-employed individuals, the number of small employer groups by size of the group and the number of covered lives;

(iii) Premiums charged; and

(iv) The number of sole proprietors or self-employed individuals who have qualified in the past twelve-month period for coverage through the Washington state health insurance pool due to the results of the standard health questionnaire.

NEW SECTION. **Sec. 10.** Section 4 of this act takes effect January

1 1, 2004."

2 Correct the title.

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