

ESHB 2460 - S AMD 870

By Senators Deccio, Thibaudeau

ADOPTED 03/11/2004

1 Strike everything after the enacting clause and insert the
2 following:

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

5 (1)(a) An insurer offering any health benefit plan to a small
6 employer (~~shall~~), either directly or through an association or
7 member-governed group formed specifically for the purpose of purchasing
8 health care, may offer and actively market to the small employer a
9 health benefit plan (~~providing benefits identical to the schedule of~~
10 ~~covered health services that are required to be delivered to an~~
11 ~~individual enrolled in the basic health plan)) featuring a limited
12 schedule of covered health care services. Nothing in this subsection
13 shall preclude an insurer from offering, or a small employer from
14 purchasing, other health benefit plans that may have more (~~or less~~)
15 comprehensive benefits than (~~the basic health plan, provided such~~
16 ~~plans are in accordance with this chapter~~) those included in the
17 product offered under this subsection. An insurer offering a health
18 benefit plan (~~that does not include benefits in the basic health~~
19 ~~plan~~) under this subsection shall clearly disclose (~~these~~
20 ~~differences~~) all covered benefits to the small employer in a brochure
21 (~~approved by~~) filed with the commissioner.~~

22 (b) A health benefit plan offered under this subsection shall
23 provide coverage for hospital expenses and services rendered by a
24 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
25 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,
26 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,
27 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244,
28 48.21.250, 48.21.300, 48.21.310, or 48.21.320 (~~if: (i) The health~~
29 ~~benefit plan is the mandatory offering under (a) of this subsection~~
30 ~~that provides benefits identical to the basic health plan, to the~~

1 ~~extent these requirements differ from the basic health plan; or (ii)~~
2 ~~the health benefit plan is offered to employers with not more than~~
3 ~~twenty five employees)).~~

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

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

13 (a) The insurer shall develop its rates based on an adjusted
14 community rate and may only vary the adjusted community rate for:

- 15 (i) Geographic area;
- 16 (ii) Family size;
- 17 (iii) Age; and
- 18 (iv) Wellness activities.

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

23 (c) The insurer shall be permitted to develop separate rates for
24 individuals age sixty-five or older for coverage for which medicare is
25 the primary payer and coverage for which medicare is not the primary
26 payer. Both rates shall be subject to the requirements of this
27 subsection (3).

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

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

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

- 38 (i) Changes to the enrollment of the small employer;
- 39 (ii) Changes to the family composition of the employee;

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

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

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

8 (h) For the purposes of this section, a health benefit plan that
9 contains a restricted network provision shall not be considered similar
10 coverage to a health benefit plan that does not contain such a
11 provision, provided that the restrictions of benefits to network
12 providers result in substantial differences in claims costs. A carrier
13 may develop its rates based on claims costs due to network provider
14 reimbursement schedules or type of network. This subsection does not
15 restrict or enhance the portability of benefits as provided in RCW
16 48.43.015.

17 (i) Adjusted community rates established under this section shall
18 pool the medical experience of all small groups purchasing coverage.
19 However, annual rate adjustments for each small group health benefit
20 plan may vary by up to plus or minus four percentage points from the
21 overall adjustment of a carrier's entire small group pool, such overall
22 adjustment to be approved by the commissioner, upon a showing by the
23 carrier, certified by a member of the American academy of actuaries
24 that: (i) The variation is a result of deductible leverage, benefit
25 design, or provider network characteristics; and (ii) for a rate
26 renewal period, the projected weighted average of all small group
27 benefit plans will have a revenue neutral effect on the carrier's small
28 group pool. Variations of greater than four percentage points are
29 subject to review by the commissioner, and must be approved or denied
30 within sixty days of submittal. A variation that is not denied within
31 sixty days shall be deemed approved. The commissioner must provide to
32 the carrier a detailed actuarial justification for any denial within
33 thirty days of the denial.

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

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

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

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

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

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

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

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

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

30 **Sec. 2.** RCW 48.43.005 and 2001 c 196 s 5 and 2001 c 147 s 1 are
31 each reenacted and amended to read as follows:

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

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

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

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

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

9 (5) "Catastrophic health plan" means:

10 (a) In the case of a contract, agreement, or policy covering a
11 single enrollee, a health benefit plan requiring a calendar year
12 deductible of, at a minimum, one thousand five hundred dollars and an
13 annual out-of-pocket expense required to be paid under the plan (other
14 than for premiums) for covered benefits of at least three thousand
15 dollars; and

16 (b) In the case of a contract, agreement, or policy covering more
17 than one enrollee, a health benefit plan requiring a calendar year
18 deductible of, at a minimum, three thousand dollars and an annual out-
19 of-pocket expense required to be paid under the plan (other than for
20 premiums) for covered benefits of at least five thousand five hundred
21 dollars; or

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

27 (6) "Certification" means a determination by a review organization
28 that an admission, extension of stay, or other health care service or
29 procedure has been reviewed and, based on the information provided,
30 meets the clinical requirements for medical necessity, appropriateness,
31 level of care, or effectiveness under the auspices of the applicable
32 health benefit plan.

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

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

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

4 (10) "Eligible employee" means an employee who works on a full-time
5 basis with a normal work week of thirty or more hours. The term
6 includes a self-employed individual, including a sole proprietor, a
7 partner of a partnership, and may include an independent contractor, if
8 the self-employed individual, sole proprietor, partner, or independent
9 contractor is included as an employee under a health benefit plan of a
10 small employer, but does not work less than thirty hours per week and
11 derives at least seventy-five percent of his or her income from a trade
12 or business through which he or she has attempted to earn taxable
13 income and for which he or she has filed the appropriate internal
14 revenue service form. Persons covered under a health benefit plan
15 pursuant to the consolidated omnibus budget reconciliation act of 1986
16 shall not be considered eligible employees for purposes of minimum
17 participation requirements of chapter 265, Laws of 1995.

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

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

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

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

1 (15) "Health care facility" or "facility" means hospices licensed
2 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
3 rural health care facilities as defined in RCW 70.175.020, psychiatric
4 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
5 under chapter 18.51 RCW, community mental health centers licensed under
6 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
7 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
8 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
9 facilities licensed under chapter 70.96A RCW, and home health agencies
10 licensed under chapter 70.127 RCW, and includes such facilities if
11 owned and operated by a political subdivision or instrumentality of the
12 state and such other facilities as required by federal law and
13 implementing regulations.

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

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

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

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

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

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

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

31 (b) Medicare supplemental health insurance governed by chapter
32 48.66 RCW;

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

35 (d) Disability income;

36 (e) Coverage incidental to a property/casualty liability insurance
37 policy such as automobile personal injury protection coverage and
38 homeowner guest medical;

39 (f) Workers' compensation coverage;

- 1 (g) Accident only coverage;
- 2 (h) Specified disease and hospital confinement indemnity when
3 marketed solely as a supplement to a health plan;
- 4 (i) Employer-sponsored self-funded health plans;
- 5 (j) Dental only and vision only coverage; and
- 6 (k) Plans deemed by the insurance commissioner to have a short-term
7 limited purpose or duration, or to be a student-only plan that is
8 guaranteed renewable while the covered person is enrolled as a regular
9 full-time undergraduate or graduate student at an accredited higher
10 education institution, after a written request for such classification
11 by the carrier and subsequent written approval by the insurance
12 commissioner.

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

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

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

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

31 (24) "Small employer" or "small group" means any person, firm,
32 corporation, partnership, association, political subdivision, sole
33 proprietor, or self-employed individual that is actively engaged in
34 business that, on at least fifty percent of its working days during the
35 preceding calendar quarter, employed at least two but no more than
36 fifty eligible employees, with a normal work week of thirty or more
37 hours, the majority of whom were employed within this state, and is not
38 formed primarily for purposes of buying health insurance and in which
39 a bona fide employer-employee relationship exists. In determining the

1 number of eligible employees, companies that are affiliated companies,
2 or that are eligible to file a combined tax return for purposes of
3 taxation by this state, shall be considered an employer. Subsequent to
4 the issuance of a health plan to a small employer and for the purpose
5 of determining eligibility, the size of a small employer shall be
6 determined annually. Except as otherwise specifically provided, a
7 small employer shall continue to be considered a small employer until
8 the plan anniversary following the date the small employer no longer
9 meets the requirements of this definition. (~~The term "small employer"~~
10 ~~includes a self-employed individual or sole proprietor. The term~~
11 ~~"small employer" also includes~~) A self-employed individual or sole
12 proprietor (~~who derives~~) must derive at least seventy-five percent of
13 his or her income from a trade or business through which the individual
14 or sole proprietor has attempted to earn taxable income and for which
15 he or she has filed the appropriate internal revenue service form 1040,
16 schedule C or F, for the previous taxable year except for a self-
17 employed individual or sole proprietor in an agricultural trade or
18 business, who must derive at least fifty-one percent of his or her
19 income from the trade or business through which the individual or sole
20 proprietor has attempted to earn taxable income and for which he or she
21 has filed the appropriate internal revenue service form 1040, for the
22 previous taxable year. A self-employed individual or sole proprietor
23 who is covered as a group of one on the day prior to the effective date
24 of this section shall also be considered a "small employer" to the
25 extent that individual or group of one is entitled to have his or her
26 coverage renewed as provided in RCW 48.43.035(6).

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

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

1 **Sec. 3.** RCW 48.43.018 and 2001 c 196 s 8 are each amended to read
2 as follows:

3 (1) Except as provided in (a) through (~~(e)~~) (e) of this
4 subsection, a health carrier may require any person applying for an
5 individual health benefit plan to complete the standard health
6 questionnaire designated under chapter 48.41 RCW.

7 (a) If a person is seeking an individual health benefit plan due to
8 his or her change of residence from one geographic area in Washington
9 state to another geographic area in Washington state where his or her
10 current health plan is not offered, completion of the standard health
11 questionnaire shall not be a condition of coverage if application for
12 coverage is made within ninety days of relocation.

13 (b) If a person is seeking an individual health benefit plan:

14 (i) Because a health care provider with whom he or she has an
15 established care relationship and from whom he or she has received
16 treatment within the past twelve months is no longer part of the
17 carrier's provider network under his or her existing Washington
18 individual health benefit plan; and

19 (ii) His or her health care provider is part of another carrier's
20 provider network; and

21 (iii) Application for a health benefit plan under that carrier's
22 provider network individual coverage is made within ninety days of his
23 or her provider leaving the previous carrier's provider network; then
24 completion of the standard health questionnaire shall not be a
25 condition of coverage.

26 (c) If a person is seeking an individual health benefit plan due to
27 his or her having exhausted continuation coverage provided under 29
28 U.S.C. Sec. 1161 et seq., completion of the standard health
29 questionnaire shall not be a condition of coverage if application for
30 coverage is made within ninety days of exhaustion of continuation
31 coverage. A health carrier shall accept an application without a
32 standard health questionnaire from a person currently covered by such
33 continuation coverage if application is made within ninety days prior
34 to the date the continuation coverage would be exhausted and the
35 effective date of the individual coverage applied for is the date the
36 continuation coverage would be exhausted, or within ninety days
37 thereafter.

38 (d) If a person is seeking an individual health benefit plan due to
39 his or her receiving notice that his or her coverage under a conversion

1 contract is discontinued, completion of the standard health
2 questionnaire shall not be a condition of coverage if application for
3 coverage is made within ninety days of discontinuation of eligibility
4 under the conversion contract. A health carrier shall accept an
5 application without a standard health questionnaire from a person
6 currently covered by such conversion contract if application is made
7 within ninety days prior to the date eligibility under the conversion
8 contract would be discontinued and the effective date of the individual
9 coverage applied for is the date eligibility under the conversion
10 contract would be discontinued, or within ninety days thereafter.

11 (e) If a person is seeking an individual health benefit plan and,
12 but for the number of persons employed by his or her employer, would
13 have qualified for continuation coverage provided under 29 U.S.C. Sec.
14 1161 et seq., completion of the standard health questionnaire shall not
15 be a condition of coverage if: (i) Application for coverage is made
16 within ninety days of a qualifying event as defined in 29 U.S.C. Sec.
17 1163; and (ii) the person had at least twenty-four months of continuous
18 group coverage immediately prior to the qualifying event. A health
19 carrier shall accept an application without a standard health
20 questionnaire from a person with at least twenty-four months of
21 continuous group coverage if application is made no more than ninety
22 days prior to the date of a qualifying event and the effective date of
23 the individual coverage applied for is the date of the qualifying
24 event, or within ninety days thereafter.

25 (2) If, based upon the results of the standard health
26 questionnaire, the person qualifies for coverage under the Washington
27 state health insurance pool, the following shall apply:

28 (a) The carrier may decide not to accept the person's application
29 for enrollment in its individual health benefit plan; and

30 (b) Within fifteen business days of receipt of a completed
31 application, the carrier shall provide written notice of the decision
32 not to accept the person's application for enrollment to both the
33 person and the administrator of the Washington state health insurance
34 pool. The notice to the person shall state that the person is eligible
35 for health insurance provided by the Washington state health insurance
36 pool, and shall include information about the Washington state health
37 insurance pool and an application for such coverage. If the carrier
38 does not provide or postmark such notice within fifteen business days,
39 the application is deemed approved.

1 (3) If the person applying for an individual health benefit plan:
2 (a) Does not qualify for coverage under the Washington state health
3 insurance pool based upon the results of the standard health
4 questionnaire; (b) does qualify for coverage under the Washington state
5 health insurance pool based upon the results of the standard health
6 questionnaire and the carrier elects to accept the person for
7 enrollment; or (c) is not required to complete the standard health
8 questionnaire designated under this chapter under subsection (1)(a) or
9 (b) of this section, the carrier shall accept the person for enrollment
10 if he or she resides within the carrier's service area and provide or
11 assure the provision of all covered services regardless of age, sex,
12 family structure, ethnicity, race, health condition, geographic
13 location, employment status, socioeconomic status, other condition or
14 situation, or the provisions of RCW 49.60.174(2). The commissioner may
15 grant a temporary exemption from this subsection if, upon application
16 by a health carrier, the commissioner finds that the clinical,
17 financial, or administrative capacity to serve existing enrollees will
18 be impaired if a health carrier is required to continue enrollment of
19 additional eligible individuals.

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

22 For group health benefit plans, the following shall apply:

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

35 (2) Except as provided in subsection (5) of this section, all
36 health plans shall contain or incorporate by endorsement a guarantee of
37 the continuity of coverage of the plan. For the purposes of this
38 section, a plan is "renewed" when it is continued beyond the earliest

1 date upon which, at the carrier's sole option, the plan could have been
2 terminated for other than nonpayment of premium. The carrier may
3 consider the group's anniversary date as the renewal date for purposes
4 of complying with the provisions of this section.

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

8 (a) Nonpayment of premium;

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

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

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

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

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

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

22 (4) The provisions of this section do not apply in the following
23 cases:

24 (a) A carrier has zero enrollment on a product; (~~(e)~~)

25 (b) A carrier replaces a product and the replacement product is
26 provided to all covered persons within that class or line of business,
27 includes all of the services covered under the replaced product, and
28 does not significantly limit access to the kind of services covered
29 under the replaced product. The health plan may also allow
30 unrestricted conversion to a fully comparable product; (~~(e)~~)

31 (c) No sooner than January 1, 2005, a carrier discontinues offering
32 a particular type of health benefit plan offered for groups of up to
33 two hundred if: (i) The carrier provides notice to each group of the
34 discontinuation at least ninety days prior to the date of the
35 discontinuation; (ii) the carrier offers to each group provided
36 coverage of this type the option to enroll, with regard to small
37 employer groups, in any other small employer group plan, or with regard
38 to groups of up to two hundred, in any other applicable group plan,
39 currently being offered by the carrier in the applicable group market;

1 and (iii) in exercising the option to discontinue coverage of this type
2 and in offering the option of coverage under (c)(ii) of this
3 subsection, the carrier acts uniformly without regard to any health
4 status-related factor of enrolled individuals or individuals who may
5 become eligible for this coverage;

6 (d) A carrier discontinues offering all health coverage in the
7 small group market or for groups of up to two hundred, or both markets,
8 in the state and discontinues coverage under all existing group health
9 benefit plans in the applicable market involved if: (i) The carrier
10 provides notice to the commissioner of its intent to discontinue
11 offering all such coverage in the state and its intent to discontinue
12 coverage under all such existing health benefit plans at least one
13 hundred eighty days prior to the date of the discontinuation of
14 coverage under all such existing health benefit plans; and (ii) the
15 carrier provides notice to each covered group of the intent to
16 discontinue the existing health benefit plan at least one hundred
17 eighty days prior to the date of discontinuation. In the case of
18 discontinuation under this subsection, the carrier may not issue any
19 group health coverage in this state in the applicable group market
20 involved for a five-year period beginning on the date of the
21 discontinuation of the last health benefit plan not so renewed. This
22 subsection (4) does not require a carrier to provide notice to the
23 commissioner of its intent to discontinue offering a health benefit
24 plan to new applicants when the carrier does not discontinue coverage
25 of existing enrollees under that health benefit plan; or

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

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

35 (6) Notwithstanding any other provision of this section, the
36 guarantee of continuity of coverage applies to a group of one only if:

37 (a) The carrier continues to offer any other small employer group plan
38 in which the group of one was eligible to enroll on the day prior to

1 the effective date of this section; and (b) the person continues to
2 qualify as a group of one under the criteria in place on the day prior
3 to the effective date of this section.

4 **Sec. 5.** RCW 48.43.038 and 2000 c 79 s 25 are each amended to read
5 as follows:

6 (1) Except as provided in subsection (4) of this section, all
7 individual health plans shall contain or incorporate by endorsement a
8 guarantee of the continuity of coverage of the plan. For the purposes
9 of this section, a plan is "renewed" when it is continued beyond the
10 earliest date upon which, at the carrier's sole option, the plan could
11 have been terminated for other than nonpayment of premium.

12 (2) The guarantee of continuity of coverage required in individual
13 health plans shall not prevent a carrier from canceling or nonrenewing
14 a health plan for:

15 (a) Nonpayment of premium;

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

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

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

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

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

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

29 (3) This section does not apply in the following cases:

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

31 (b) A carrier is withdrawing from a service area or from a segment
32 of its service area because the carrier has demonstrated to the
33 commissioner that the carrier's clinical, financial, or administrative
34 capacity to serve enrollees would be exceeded;

35 (c) No sooner than the first day of the month following the
36 expiration of a one hundred eighty-day period beginning on March 23,
37 2000, a carrier discontinues offering a particular type of health
38 benefit plan offered in the individual market, including conversion

1 contracts, if: (i) The carrier provides notice to each covered
2 individual provided coverage of this type of such discontinuation at
3 least ninety days prior to the date of the discontinuation; (ii) the
4 carrier offers to each individual provided coverage of this type the
5 option, without being subject to the standard health questionnaire, to
6 enroll in any other individual health benefit plan currently being
7 offered by the carrier; and (iii) in exercising the option to
8 discontinue coverage of this type and in offering the option of
9 coverage under (c)(ii) of this subsection, the carrier acts uniformly
10 without regard to any health status-related factor of enrolled
11 individuals or individuals who may become eligible for such coverage;
12 or

13 (d) A carrier discontinues offering all individual health coverage
14 in the state and discontinues coverage under all existing individual
15 health benefit plans if: (i) The carrier provides notice to the
16 commissioner of its intent to discontinue offering all individual
17 health coverage in the state and its intent to discontinue coverage
18 under all existing health benefit plans at least one hundred eighty
19 days prior to the date of the discontinuation of coverage under all
20 existing health benefit plans; and (ii) the carrier provides notice to
21 each covered individual of the intent to discontinue his or her
22 existing health benefit plan at least one hundred eighty days prior to
23 the date of such discontinuation. In the case of discontinuation under
24 this subsection, the carrier may not issue any individual health
25 coverage in this state for a five-year period beginning on the date of
26 the discontinuation of the last health plan not so renewed. Nothing in
27 this subsection (3) shall be construed to require a carrier to provide
28 notice to the commissioner of its intent to discontinue offering a
29 health benefit plan to new applicants where the carrier does not
30 discontinue coverage of existing enrollees under that health benefit
31 plan.

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

36 **Sec. 6.** RCW 48.44.022 and 2000 c 79 s 30 are each amended to read
37 as follows:

1 (1) Premium rates for health benefit plans for individuals shall be
2 subject to the following provisions:

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

- 6 (i) Geographic area;
- 7 (ii) Family size;
- 8 (iii) Age;
- 9 (iv) Tenure discounts; and
- 10 (v) Wellness activities.

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

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

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

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

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

- 30 (i) Changes to the family composition;
- 31 (ii) Changes to the health benefit plan requested by the
32 individual; or
- 33 (iii) Changes in government requirements affecting the health
34 benefit plan.

35 (g) For the purposes of this section, a health benefit plan that
36 contains a restricted network provision shall not be considered similar
37 coverage to a health benefit plan that does not contain such a
38 provision, provided that the restrictions of benefits to network

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

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

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

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

13 **Sec. 7.** RCW 48.44.023 and 1995 c 265 s 16 are each amended to read
14 as follows:

15 (1)(a) A health care services contractor offering any health
16 benefit plan to a small employer (~~(shall)~~), either directly or through
17 an association or member-governed group formed specifically for the
18 purpose of purchasing health care, may offer and actively market to the
19 small employer a health benefit plan (~~(providing benefits identical to~~
20 ~~the schedule of covered health services that are required to be~~
21 ~~delivered to an individual enrolled in the basic health plan))~~
22 featuring a limited schedule of covered health care services. Nothing
23 in this subsection shall preclude a contractor from offering, or a
24 small employer from purchasing, other health benefit plans that may
25 have more (~~(or less)~~) comprehensive benefits than (~~(the basic health~~
26 ~~plan, provided such plans are in accordance with this chapter))~~ those
27 included in the product offered under this subsection. A contractor
28 offering a health benefit plan (~~(that does not include benefits in the~~
29 ~~basic health plan))~~ under this subsection shall clearly disclose
30 (~~(these differences))~~ all covered benefits to the small employer in a
31 brochure (~~(approved by)~~) filed with the commissioner.

32 (b) A health benefit plan offered under this subsection shall
33 provide coverage for hospital expenses and services rendered by a
34 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
35 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,
36 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,
37 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and
38 48.44.460 (~~(if: (i) The health benefit plan is the mandatory offering~~

1 ~~under (a) of this subsection that provides benefits identical to the~~
2 ~~basic health plan, to the extent these requirements differ from the~~
3 ~~basic health plan; or (ii) the health benefit plan is offered to~~
4 ~~employers with not more than twenty five employees)).~~

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

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

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

- 16 (i) Geographic area;
- 17 (ii) Family size;
- 18 (iii) Age; and
- 19 (iv) Wellness activities.

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

24 (c) The contractor shall be permitted to develop separate rates for
25 individuals age sixty-five or older for coverage for which medicare is
26 the primary payer and coverage for which medicare is not the primary
27 payer. Both rates shall be subject to the requirements of this
28 subsection (3).

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

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

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

- 39 (i) Changes to the enrollment of the small employer;

1 (ii) Changes to the family composition of the employee;
2 (iii) Changes to the health benefit plan requested by the small
3 employer; or
4 (iv) Changes in government requirements affecting the health
5 benefit plan.

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

9 (h) For the purposes of this section, a health benefit plan that
10 contains a restricted network provision shall not be considered similar
11 coverage to a health benefit plan that does not contain such a
12 provision, provided that the restrictions of benefits to network
13 providers result in substantial differences in claims costs. A carrier
14 may develop its rates based on claims costs due to network provider
15 reimbursement schedules or type of network. This subsection does not
16 restrict or enhance the portability of benefits as provided in RCW
17 48.43.015.

18 (i) Adjusted community rates established under this section shall
19 pool the medical experience of all groups purchasing coverage.
20 However, annual rate adjustments for each small group health benefit
21 plan may vary by up to plus or minus four percentage points from the
22 overall adjustment of a carrier's entire small group pool, such overall
23 adjustment to be approved by the commissioner, upon a showing by the
24 carrier, certified by a member of the American academy of actuaries
25 that: (i) The variation is a result of deductible leverage, benefit
26 design, or provider network characteristics; and (ii) for a rate
27 renewal period, the projected weighted average of all small group
28 benefit plans will have a revenue neutral effect on the carrier's small
29 group pool. Variations of greater than four percentage points are
30 subject to review by the commissioner, and must be approved or denied
31 within sixty days of submittal. A variation that is not denied within
32 sixty days shall be deemed approved. The commissioner must provide to
33 the carrier a detailed actuarial justification for any denial within
34 thirty days of the denial.

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

1 bargain for insurance providing benefits in excess of those provided
2 herein.

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

7 (b) A contractor shall not require a minimum participation level
8 greater than:

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

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

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

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

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

29 **Sec. 8.** RCW 48.46.064 and 2000 c 79 s 33 are each amended to read
30 as follows:

31 (1) Premium rates for health benefit plans for individuals shall be
32 subject to the following provisions:

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

36 (i) Geographic area;

37 (ii) Family size;

38 (iii) Age;

1 (iv) Tenure discounts; and

2 (v) Wellness activities.

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

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

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

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

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

22 (i) Changes to the family composition;

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

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

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

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

36 (2) Adjusted community rates established under this section shall
37 pool the medical experience of all individuals purchasing coverage, and
38 shall not be required to be pooled with the medical experience of
39 health benefit plans offered to small employers under RCW 48.46.066.

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

4 **Sec. 9.** RCW 48.46.066 and 1995 c 265 s 18 are each amended to read
5 as follows:

6 (1)(a) A health maintenance organization offering any health
7 benefit plan to a small employer (~~(shall)~~), either directly or through
8 an association or member-governed group formed specifically for the
9 purpose of purchasing health care, may offer and actively market to the
10 small employer a health benefit plan (~~((providing benefits identical to~~
11 ~~the schedule of covered health services that are required to be~~
12 ~~delivered to an individual enrolled in the basic health plan))~~)
13 featuring a limited schedule of covered health care services. Nothing
14 in this subsection shall preclude a health maintenance organization
15 from offering, or a small employer from purchasing, other health
16 benefit plans that may have more (~~(or less)~~) comprehensive benefits
17 than (~~(the basic health plan, provided such plans are in accordance~~
18 ~~with this chapter))~~) those included in the product offered under this
19 subsection. A health maintenance organization offering a health
20 benefit plan (~~(that does not include benefits in the basic health~~
21 ~~plan))~~) under this subsection shall clearly disclose (~~(these~~
22 ~~differences))~~) all the covered benefits to the small employer in a
23 brochure (~~(approved by)~~) filed with the commissioner.

24 (b) A health benefit plan offered under this subsection shall
25 provide coverage for hospital expenses and services rendered by a
26 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
27 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290,
28 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510,
29 48.46.520, and 48.46.530 (~~((if: (i) The health benefit plan is the~~
30 ~~mandatory offering under (a) of this subsection that provides benefits~~
31 ~~identical to the basic health plan, to the extent these requirements~~
32 ~~differ from the basic health plan; or (ii) the health benefit plan is~~
33 ~~offered to employers with not more than twenty five employees))~~).

34 (2) Nothing in this section shall prohibit a health maintenance
35 organization from offering, or a purchaser from seeking, health benefit
36 plans with benefits in excess of the (~~(basic health plan services))~~)
37 health benefit plan offered under subsection (1) of this section. All

1 forms, policies, and contracts shall be submitted for approval to the
2 commissioner, and the rates of any plan offered under this section
3 shall be reasonable in relation to the benefits thereto.

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

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

- 9 (i) Geographic area;
- 10 (ii) Family size;
- 11 (iii) Age; and
- 12 (iv) Wellness activities.

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

17 (c) The health maintenance organization shall be permitted to
18 develop separate rates for individuals age sixty-five or older for
19 coverage for which medicare is the primary payer and coverage for which
20 medicare is not the primary payer. Both rates shall be subject to the
21 requirements of this subsection (3).

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

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

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

- 32 (i) Changes to the enrollment of the small employer;
- 33 (ii) Changes to the family composition of the employee;
- 34 (iii) Changes to the health benefit plan requested by the small
35 employer; or
- 36 (iv) Changes in government requirements affecting the health
37 benefit plan.

38 (g) Rating factors shall produce premiums for identical groups that

1 differ only by the amounts attributable to plan design, with the
2 exception of discounts for health improvement programs.

3 (h) For the purposes of this section, a health benefit plan that
4 contains a restricted network provision shall not be considered similar
5 coverage to a health benefit plan that does not contain such a
6 provision, provided that the restrictions of benefits to network
7 providers result in substantial differences in claims costs. A carrier
8 may develop its rates based on claims costs due to network provider
9 reimbursement schedules or type of network. This subsection does not
10 restrict or enhance the portability of benefits as provided in RCW
11 48.43.015.

12 (i) Adjusted community rates established under this section shall
13 pool the medical experience of all groups purchasing coverage.
14 However, annual rate adjustments for each small group health benefit
15 plan may vary by up to plus or minus four percentage points from the
16 overall adjustment of a carrier's entire small group pool, such overall
17 adjustment to be approved by the commissioner, upon a showing by the
18 carrier, certified by a member of the American academy of actuaries
19 that: (i) The variation is a result of deductible leverage, benefit
20 design, or provider network characteristics; and (ii) for a rate
21 renewal period, the projected weighted average of all small group
22 benefit plans will have a revenue neutral effect on the carrier's small
23 group pool. Variations of greater than four percentage points are
24 subject to review by the commissioner, and must be approved or denied
25 within sixty days of submittal. A variation that is not denied within
26 sixty days shall be deemed approved. The commissioner must provide to
27 the carrier a detailed actuarial justification for any denial within
28 thirty days of the denial.

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

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

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

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

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

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

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

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

25 **Sec. 10.** RCW 48.21.143 and 1997 c 276 s 3 are each amended to read
26 as follows:

27 The legislature finds that diabetes imposes a significant health
28 risk and tremendous financial burden on the citizens and government of
29 the state of Washington, and that access to the medically accepted
30 standards of care for diabetes, its treatment and supplies, and self-
31 management training and education is crucial to prevent or delay the
32 short and long-term complications of diabetes and its attendant costs.

33 (1) The definitions in this subsection apply throughout this
34 section unless the context clearly requires otherwise.

35 (a) "Person with diabetes" means a person diagnosed by a health
36 care provider as having insulin using diabetes, noninsulin using
37 diabetes, or elevated blood glucose levels induced by pregnancy; and

1 (b) "Health care provider" means a health care provider as defined
2 in RCW 48.43.005.

3 (2) All group disability insurance contracts and blanket disability
4 insurance contracts providing health care services, issued or renewed
5 after January 1, 1998, shall provide benefits for at least the
6 following services and supplies for persons with diabetes:

7 (a) For group disability insurance contracts and blanket disability
8 insurance contracts that include coverage for pharmacy services,
9 appropriate and medically necessary equipment and supplies, as
10 prescribed by a health care provider, that includes but is not limited
11 to insulin, syringes, injection aids, blood glucose monitors, test
12 strips for blood glucose monitors, visual reading and urine test
13 strips, insulin pumps and accessories to the pumps, insulin infusion
14 devices, prescriptive oral agents for controlling blood sugar levels,
15 foot care appliances for prevention of complications associated with
16 diabetes, and glucagon emergency kits; and

17 (b) For all group disability insurance contracts and blanket
18 disability insurance contracts providing health care services,
19 outpatient self-management training and education, including medical
20 nutrition therapy, as ordered by the health care provider. Diabetes
21 outpatient self-management training and education may be provided only
22 by health care providers with expertise in diabetes. Nothing in this
23 section prevents the insurer from restricting patients to seeing only
24 health care providers who have signed participating provider agreements
25 with the insurer or an insuring entity under contract with the insurer.

26 (3) Coverage required under this section may be subject to
27 customary cost-sharing provisions established for all other similar
28 services or supplies within a policy.

29 (4) Health care coverage may not be reduced or eliminated due to
30 this section.

31 (5) Services required under this section shall be covered when
32 deemed medically necessary by the medical director, or his or her
33 designee, subject to any referral and formulary requirements.

34 (6) The insurer need not include the coverage required in this
35 section in a group contract offered to an employer or other group that
36 offers to its eligible enrollees a self-insured health plan not subject
37 to mandated benefits status under this title that does not offer
38 coverage similar to that mandated under this section.

1 (7) This section does not apply to the health benefit plan that
2 provides benefits identical to the schedule of services covered by the
3 basic health plan(~~(, as required by RCW 48.21.045)~~).

4 **Sec. 11.** RCW 48.21.250 and 1984 c 190 s 2 are each amended to read
5 as follows:

6 Every insurer that issues policies providing group coverage for
7 hospital or medical expense shall offer the policyholder an option to
8 include a policy provision granting a person who becomes ineligible for
9 coverage under the group policy, the right to continue the group
10 benefits for a period of time and at a rate agreed upon. ~~((The policy
11 provision shall provide that when such coverage terminates, the covered
12 person may convert to a policy as provided in RCW 48.21.260.))~~

13 **Sec. 12.** RCW 48.44.315 and 1997 c 276 s 4 are each amended to read
14 as follows:

15 The legislature finds that diabetes imposes a significant health
16 risk and tremendous financial burden on the citizens and government of
17 the state of Washington, and that access to the medically accepted
18 standards of care for diabetes, its treatment and supplies, and self-
19 management training and education is crucial to prevent or delay the
20 short and long-term complications of diabetes and its attendant costs.

21 (1) The definitions in this subsection apply throughout this
22 section unless the context clearly requires otherwise.

23 (a) "Person with diabetes" means a person diagnosed by a health
24 care provider as having insulin using diabetes, noninsulin using
25 diabetes, or elevated blood glucose levels induced by pregnancy; and

26 (b) "Health care provider" means a health care provider as defined
27 in RCW 48.43.005.

28 (2) All health benefit plans offered by health care service
29 contractors, issued or renewed after January 1, 1998, shall provide
30 benefits for at least the following services and supplies for persons
31 with diabetes:

32 (a) For health benefit plans that include coverage for pharmacy
33 services, appropriate and medically necessary equipment and supplies,
34 as prescribed by a health care provider, that includes but is not
35 limited to insulin, syringes, injection aids, blood glucose monitors,
36 test strips for blood glucose monitors, visual reading and urine test
37 strips, insulin pumps and accessories to the pumps, insulin infusion

1 devices, prescriptive oral agents for controlling blood sugar levels,
2 foot care appliances for prevention of complications associated with
3 diabetes, and glucagon emergency kits; and

4 (b) For all health benefit plans, outpatient self-management
5 training and education, including medical nutrition therapy, as ordered
6 by the health care provider. Diabetes outpatient self-management
7 training and education may be provided only by health care providers
8 with expertise in diabetes. Nothing in this section prevents the
9 health care services contractor from restricting patients to seeing
10 only health care providers who have signed participating provider
11 agreements with the health care services contractor or an insuring
12 entity under contract with the health care services contractor.

13 (3) Coverage required under this section may be subject to
14 customary cost-sharing provisions established for all other similar
15 services or supplies within a policy.

16 (4) Health care coverage may not be reduced or eliminated due to
17 this section.

18 (5) Services required under this section shall be covered when
19 deemed medically necessary by the medical director, or his or her
20 designee, subject to any referral and formulary requirements.

21 (6) The health care service contractor need not include the
22 coverage required in this section in a group contract offered to an
23 employer or other group that offers to its eligible enrollees a self-
24 insured health plan not subject to mandated benefits status under this
25 title that does not offer coverage similar to that mandated under this
26 section.

27 (7) This section does not apply to the health benefit plans that
28 provide benefits identical to the schedule of services covered by the
29 basic health plan(~~(, as required by RCW 48.44.022 and 48.44.023)~~).

30 **Sec. 13.** RCW 48.44.360 and 1984 c 190 s 5 are each amended to read
31 as follows:

32 Every health care service contractor that issues group contracts
33 providing group coverage for hospital or medical expense shall offer
34 the contract holder an option to include a contract provision granting
35 a person who becomes ineligible for coverage under the group contract,
36 the right to continue the group benefits for a period of time and at a
37 rate agreed upon. (~~The contract provision shall provide that when~~

1 ~~such coverage terminates, the covered person may convert to a contract~~
2 ~~as provided in RCW 48.44.370.)~~)

3 **Sec. 14.** RCW 48.46.272 and 1997 c 276 s 5 are each amended to read
4 as follows:

5 The legislature finds that diabetes imposes a significant health
6 risk and tremendous financial burden on the citizens and government of
7 the state of Washington, and that access to the medically accepted
8 standards of care for diabetes, its treatment and supplies, and self-
9 management training and education is crucial to prevent or delay the
10 short and long-term complications of diabetes and its attendant costs.

11 (1) The definitions in this subsection apply throughout this
12 section unless the context clearly requires otherwise.

13 (a) "Person with diabetes" means a person diagnosed by a health
14 care provider as having insulin using diabetes, noninsulin using
15 diabetes, or elevated blood glucose levels induced by pregnancy; and

16 (b) "Health care provider" means a health care provider as defined
17 in RCW 48.43.005.

18 (2) All health benefit plans offered by health maintenance
19 organizations, issued or renewed after January 1, 1998, shall provide
20 benefits for at least the following services and supplies for persons
21 with diabetes:

22 (a) For health benefit plans that include coverage for pharmacy
23 services, appropriate and medically necessary equipment and supplies,
24 as prescribed by a health care provider, that includes but is not
25 limited to insulin, syringes, injection aids, blood glucose monitors,
26 test strips for blood glucose monitors, visual reading and urine test
27 strips, insulin pumps and accessories to the pumps, insulin infusion
28 devices, prescriptive oral agents for controlling blood sugar levels,
29 foot care appliances for prevention of complications associated with
30 diabetes, and glucagon emergency kits; and

31 (b) For all health benefit plans, outpatient self-management
32 training and education, including medical nutrition therapy, as ordered
33 by the health care provider. Diabetes outpatient self-management
34 training and education may be provided only by health care providers
35 with expertise in diabetes. Nothing in this section prevents the
36 health maintenance organization from restricting patients to seeing
37 only health care providers who have signed participating provider

1 agreements with the health maintenance organization or an insuring
2 entity under contract with the health maintenance organization.

3 (3) Coverage required under this section may be subject to
4 customary cost-sharing provisions established for all other similar
5 services or supplies within a policy.

6 (4) Health care coverage may not be reduced or eliminated due to
7 this section.

8 (5) Services required under this section shall be covered when
9 deemed medically necessary by the medical director, or his or her
10 designee, subject to any referral and formulary requirements.

11 (6) The health maintenance organization need not include the
12 coverage required in this section in a group contract offered to an
13 employer or other group that offers to its eligible enrollees a self-
14 insured health plan not subject to mandated benefits status under this
15 title that does not offer coverage similar to that mandated under this
16 section.

17 (7) This section does not apply to the health benefit plans that
18 provide benefits identical to the schedule of services covered by the
19 basic health plan(~~(, as required by RCW 48.46.064 and 48.46.066)~~).

20 **Sec. 15.** RCW 48.46.440 and 1984 c 190 s 8 are each amended to read
21 as follows:

22 Every health maintenance organization that issues agreements
23 providing group coverage for hospital or medical care shall offer the
24 agreement holder an option to include an agreement provision granting
25 a person who becomes ineligible for coverage under the group agreement,
26 the right to continue the group benefits for a period of time and at a
27 rate agreed upon. (~~(The agreement provision shall provide that when
28 such coverage terminates the covered person may convert to an agreement
29 as provided in RCW 48.46.450.)~~)

30 NEW SECTION. **Sec. 16.** The following acts or parts of acts are
31 each repealed:

32 (1) RCW 48.21.260 (Conversion policy to be offered--Exceptions,
33 conditions) and 1984 c 190 s 3;

34 (2) RCW 48.21.270 (Conversion policy--Restrictions and
35 requirements) and 1984 c 190 s 4;

36 (3) RCW 48.44.370 (Conversion contract to be offered--Exceptions,
37 conditions) and 1984 c 190 s 6;

1 (4) RCW 48.44.380 (Conversion contract--Restrictions and
2 requirements) and 1984 c 190 s 7;

3 (5) RCW 48.46.450 (Conversion agreement to be offered--Exceptions,
4 conditions) and 1984 c 190 s 9; and

5 (6) RCW 48.46.460 (Conversion agreement--Restrictions and
6 requirements) and 1984 c 190 s 10.

7 NEW SECTION. **Sec. 17.** Sections 1 through 15 of this act apply to
8 all small group health benefit plans issued or renewed on or after the
9 effective date of this section."

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By Senators Deccio, Thibaudeau

ADOPTED 03/11/2004

10 On page 1, line 2 of the title, after "employees;" strike the
11 remainder of the title and insert "amending RCW 48.21.045, 48.43.018,
12 48.43.035, 48.43.038, 48.44.022, 48.44.023, 48.46.064, 48.46.066,
13 48.21.143, 48.21.250, 48.44.315, 48.44.360, 48.46.272, and 48.46.440;
14 reenacting and amending RCW 48.43.005; creating a new section; and
15 repealing RCW 48.21.260, 48.21.270, 48.44.370, 48.44.380, 48.46.450,
16 and 48.46.460."

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