
HOUSE BILL 1871

State of Washington

58th Legislature

2003 Regular Session

By Representatives Pflug, Bailey, McDonald, Sehlin, Talcott, Ahern, McMahan, Priest, Bush, Anderson, Schoesler, Alexander, Shabro, Clements, Skinner, Woods, Chandler, Holmquist, Haigh, Pearson, Ericksen and Roach

Read first time 02/12/2003. Referred to Committee on Health Care.

1 AN ACT Relating to access to health insurance for employers and
2 their employees; amending RCW 48.21.045, 48.43.038, 48.43.045,
3 48.44.023, and 48.46.066; reenacting and amending RCW 48.43.005; and
4 repealing RCW 48.43.035.

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

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

8 (1)(a) An insurer offering any health benefit plan to a small
9 employer shall offer and actively market to the small employer a health
10 benefit plan (~~providing benefits identical to the schedule of covered~~
11 ~~health services that are required to be delivered to an individual~~
12 ~~enrolled in the basic health plan~~) featuring a limited schedule of
13 covered health care services. Nothing in this subsection shall
14 preclude an insurer from offering, or a small employer from purchasing,
15 other health benefit plans that may have more (~~or less~~) comprehensive
16 benefits than (~~the basic health plan, provided such plans are in~~
17 ~~accordance with this chapter~~) those included in the product offered
18 under this subsection. An insurer offering a health benefit plan
19 (~~that does not include benefits in the basic health plan~~) under this

1 subsection shall clearly disclose (~~these differences~~) all covered
2 benefits to the small employer in a brochure approved by the
3 commissioner.

4 (b) A health benefit plan offered under this subsection shall
5 provide coverage for hospital expenses and services rendered by a
6 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
7 to the requirements of RCW 48.21.130, (~~48.21.140, 48.21.141,~~)
8 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197,
9 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240,
10 48.21.244, 48.21.250, (~~48.21.300,~~) 48.21.310, or 48.21.320 (~~if: (i)~~
11 ~~The health benefit plan is the mandatory offering under (a) of this~~
12 ~~subsection that provides benefits identical to the basic health plan,~~
13 ~~to the extent these requirements differ from the basic health plan; or~~
14 ~~(ii) the health benefit plan is offered to employers with not more than~~
15 ~~twenty five employees~~)).

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

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

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

- 27 (i) Geographic area;
- 28 (ii) Family size;
- 29 (iii) Age; (~~and~~)
- 30 (iv) Wellness activities;
- 31 (v) Industry; and
- 32 (vi) Other factors that the commissioner may approve by rule.

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

37 (c) The insurer shall be permitted to develop separate rates for
38 individuals age sixty-five or older for coverage for which medicare is

1 the primary payer and coverage for which medicare is not the primary
2 payer. Both rates shall be subject to the requirements of this
3 subsection (3).

4 ~~((d)) ((The permitted rates for any age group shall be no more than
5 four hundred twenty five percent of the lowest rate for all age groups
6 on January 1, 1996, four hundred percent on January 1, 1997, and three
7 hundred seventy five percent on January 1, 2000, and thereafter.~~

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

11 ~~((f))~~) (e) The rate charged for a health benefit plan offered
12 under this section may not be adjusted more frequently than annually
13 except that the premium may be changed to reflect:

- 14 (i) Changes to the enrollment of the small employer;
- 15 (ii) Changes to the family composition of the employee;
- 16 (iii) Changes to the health benefit plan requested by the small
17 employer; or
- 18 (iv) Changes in government requirements affecting the health
19 benefit plan.

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

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

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

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

1 ~~(5)~~(a) Except as provided in this subsection, requirements used
2 by 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))~~ (5) An insurer must offer coverage to all eligible
20 employees of a small employer and their dependents. An insurer may not
21 offer coverage to only certain individuals or dependents in a small
22 employer group or to only part of the group. An insurer may not modify
23 a health plan with respect to a small employer or any eligible employee
24 or dependent, through riders, endorsements or otherwise, to restrict or
25 exclude coverage or benefits for specific diseases, medical conditions,
26 or services otherwise covered by the plan.

27 ~~((7))~~ (6) 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

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

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

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

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

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

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

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

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

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

33 (b) Medicare supplemental health insurance governed by chapter
34 48.66 RCW;

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

37 (d) Disability income;

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

4 (f) Workers' compensation coverage;

5 (g) Accident only coverage;

6 (h) Specified disease and hospital confinement indemnity when
7 marketed solely as a supplement to a health plan;

8 (i) Employer-sponsored self-funded health plans;

9 (j) Dental only and vision only coverage; and

10 (k) Plans deemed by the insurance commissioner to have a short-term
11 limited purpose or duration, or to be a student-only plan that is
12 guaranteed renewable while the covered person is enrolled as a regular
13 full-time undergraduate or graduate student at an accredited higher
14 education institution, after a written request for such classification
15 by the carrier and subsequent written approval by the insurance
16 commissioner.

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

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

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

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

35 (24) "Small employer" or "small group" means any person, firm,
36 corporation, partnership, association, political subdivision, or self-
37 employed individual that is actively engaged in business that, on at
38 least fifty percent of its working days during the preceding calendar

1 quarter, employed at least two but no more than fifty eligible
2 employees, with a normal work week of thirty or more hours, the
3 majority of whom were employed within this state, and is not formed
4 primarily for purposes of buying health insurance and in which a bona
5 fide employer-employee relationship exists. In determining the number
6 of eligible employees, companies that are affiliated companies, or that
7 are eligible to file a combined tax return for purposes of taxation by
8 this state, shall be considered an employer. Subsequent to the
9 issuance of a health plan to a small employer and for the purpose of
10 determining eligibility, the size of a small employer shall be
11 determined annually. Except as otherwise specifically provided, a
12 small employer shall continue to be considered a small employer until
13 the plan anniversary following the date the small employer no longer
14 meets the requirements of this definition. The term "small employer"
15 includes a self-employed individual or sole proprietor. The term
16 "small employer" also includes a self-employed individual or sole
17 proprietor who derives at least seventy-five percent of his or her
18 income from a trade or business through which the individual or sole
19 proprietor has attempted to earn taxable income and for which he or she
20 has filed the appropriate internal revenue service form 1040, schedule
21 C or F, for the previous taxable year.

22 (25) "Utilization review" means the prospective, concurrent, or
23 retrospective assessment of the necessity and appropriateness of the
24 allocation of health care resources and services of a provider or
25 facility, given or proposed to be given to an enrollee or group of
26 enrollees.

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

34 **Sec. 3.** RCW 48.43.038 and 2000 c 79 s 25 are each amended to read
35 as follows:

36 (1) Except as provided in subsection (4) of this section, all
37 (~~individual~~) health plans shall contain or incorporate by endorsement

1 a guarantee of the continuity of coverage of the plan. For the
2 purposes of this section, a plan is "renewed" when it is continued
3 beyond the earliest date upon which, at the carrier's sole option, the
4 plan could have been terminated for other than nonpayment of premium.

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

8 (a) Nonpayment of premium;

9 (b) Violation of published policies of the carrier approved by the
10 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 (3) This section does not apply in the following cases:

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

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

28 (c) No sooner than the first day of the month following the
29 expiration of a one hundred eighty-day period beginning on (~~March 23,~~
30 ~~2000~~) the effective date of this section, a carrier discontinues
31 offering a particular type of health benefit plan (~~offered in the~~
32 ~~individual market~~) if: (i) The carrier provides notice to each
33 covered individual or group policyholder provided coverage of this type
34 of such discontinuation at least ninety days prior to the date of the
35 discontinuation; (ii) the carrier offers to each individual or group
36 policyholder provided coverage of this type the option, without being
37 subject to the standard health questionnaire, to enroll in any other
38 individual or, for a group policyholder, a group health benefit plan

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

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

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

31 **Sec. 4.** RCW 48.43.045 and 1997 c 231 s 205 are each amended to
32 read as follows:

33 Every health plan delivered, issued for delivery, or renewed by a
34 health carrier on and after January 1, 1996, shall(÷

35 ~~(1) Permit every category of health care provider to provide health~~
36 ~~services or care for conditions included in the basic health plan~~
37 ~~services to the extent that:~~

1 ~~(a) The provision of such health services or care is within the~~
2 ~~health care providers' permitted scope of practice; and~~

3 ~~(b) The providers agree to abide by standards related to:~~

4 ~~(i) Provision, utilization review, and cost containment of health~~
5 ~~services;~~

6 ~~(ii) Management and administrative procedures; and~~

7 ~~(iii) Provision of cost effective and clinically efficacious health~~
8 ~~services.~~

9 ~~(2))~~ annually report the names and addresses of all officers,
10 directors, or trustees of the health carrier during the preceding year,
11 and the amount of wages, expense reimbursements, or other payments to
12 such individuals. This requirement does not apply to a foreign or
13 alien insurer regulated under chapter 48.20 or 48.21 RCW that files a
14 supplemental compensation exhibit in its annual statement as required
15 by law.

16 **Sec. 5.** RCW 48.44.023 and 1995 c 265 s 16 are each amended to read
17 as follows:

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

33 (b) A health benefit plan offered under this subsection shall
34 provide coverage for hospital expenses and services rendered by a
35 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
36 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245,
37 (~~48.44.290, 48.44.300,~~) 48.44.310, 48.44.320, 48.44.325, 48.44.330,

1 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, (~~48.44.440,~~)
2 48.44.450, and 48.44.460 (~~(if: (i) The health benefit plan is the~~
3 ~~mandatory offering under (a) of this subsection that provides benefits~~
4 ~~identical to the basic health plan, to the extent these requirements~~
5 ~~differ from the basic health plan; or (ii) the health benefit plan is~~
6 ~~offered to employers with not more than twenty five employees))).~~

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

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

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

18 (i) Geographic area;

19 (ii) Family size;

20 (iii) Age; (~~and~~)

21 (iv) Wellness activities;

22 (v) Industry; and

23 (vi) Other factors that the commissioner may approve by rule.

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

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

33 (~~(d) (The permitted rates for any age group shall be no more than~~
34 ~~four hundred twenty five percent of the lowest rate for all age groups~~
35 ~~on January 1, 1996, four hundred percent on January 1, 1997, and three~~
36 ~~hundred seventy five percent on January 1, 2000, and thereafter.~~

37 ~~(e))~~ A discount for wellness activities shall be permitted to

1 reflect actuarially justified differences in utilization or cost
2 attributed to such programs (~~(not to exceed twenty percent)~~).

3 ~~((f))~~ (e) The rate charged for a health benefit plan offered
4 under this section may not be adjusted more frequently than annually
5 except that the premium may be changed to reflect:

6 (i) Changes to the enrollment of the small employer;

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

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

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

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

15 ~~((h))~~ (g) For the purposes of this section, a health benefit plan
16 that contains a restricted network provision shall not be considered
17 similar coverage to a health benefit plan that does not contain such a
18 provision, provided that the restrictions of benefits to network
19 providers result in substantial differences in claims costs. This
20 subsection does not restrict or enhance the portability of benefits as
21 provided in RCW 48.43.015.

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

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

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

34 (b) A contractor shall not require a minimum participation level
35 greater than:

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

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

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

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

11 ~~((+6))~~ (5) A contractor must offer coverage to all eligible
12 employees of a small employer and their dependents. A contractor may
13 not offer coverage to only certain individuals or dependents in a small
14 employer group or to only part of the group. A contractor may not
15 modify a health plan with respect to a small employer or any eligible
16 employee or dependent, through riders, endorsements or otherwise, to
17 restrict or exclude coverage or benefits for specific diseases, medical
18 conditions, or services otherwise covered by the plan.

19 **Sec. 6.** RCW 48.46.066 and 1995 c 265 s 18 are each amended to read
20 as follows:

21 (1)(a) A health maintenance organization offering any health
22 benefit plan to a small employer shall offer and actively market to the
23 small employer a health benefit plan ~~((providing benefits identical to
24 the schedule of covered health services that are required to be
25 delivered to an individual enrolled in the basic health plan))~~
26 featuring a limited schedule of covered health care services. Nothing
27 in this subsection shall preclude a health maintenance organization
28 from offering, or a small employer from purchasing, other health
29 benefit plans that may have more ~~((or less))~~ comprehensive benefits
30 than ~~((the basic health plan, provided such plans are in accordance
31 with this chapter))~~ those included in the product offered under this
32 subsection. A health maintenance organization offering a health
33 benefit plan ~~((that does not include benefits in the basic health
34 plan))~~ under this subsection shall clearly disclose ~~((these
35 differences))~~ all the covered benefits to the small employer in a
36 brochure approved by the commissioner.

1 (b) A health benefit plan offered under this subsection shall
2 provide coverage for hospital expenses and services rendered by a
3 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
4 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290,
5 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, (~~48.46.510,~~)
6 48.46.520, and 48.46.530 (~~((if: (i) The health benefit plan is the~~
7 ~~mandatory offering under (a) of this subsection that provides benefits~~
8 ~~identical to the basic health plan, to the extent these requirements~~
9 ~~differ from the basic health plan; or (ii) the health benefit plan is~~
10 ~~offered to employers with not more than twenty five employees))~~).

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

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

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

- 23 (i) Geographic area;
- 24 (ii) Family size;
- 25 (iii) Age; (~~and~~)
- 26 (iv) Wellness activities;
- 27 (v) Industry; and
- 28 (vi) Other factors that the commissioner may approve by rule.

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

33 (c) The health maintenance organization shall be permitted to
34 develop separate rates for individuals age sixty-five or older for
35 coverage for which medicare is the primary payer and coverage for which
36 medicare is not the primary payer. Both rates shall be subject to the
37 requirements of this subsection (3).

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

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

8 ~~((f))~~ (e) The rate charged for a health benefit plan offered
9 under this section may not be adjusted more frequently than annually
10 except that the premium may be changed to reflect:

11 (i) Changes to the enrollment of the small employer;

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

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

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

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

20 ~~((h))~~ (g) For the purposes of this section, a health benefit plan
21 that contains a restricted network provision shall not be considered
22 similar coverage to a health benefit plan that does not contain such a
23 provision, provided that the restrictions of benefits to network
24 providers result in substantial differences in claims costs. This
25 subsection does not restrict or enhance the portability of benefits as
26 provided in RCW 48.43.015.

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

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 in~~
32 ~~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
36 by 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+))~~ (5) A health maintenance organization must offer coverage
17 to all eligible employees of a small employer and their dependents. A
18 health 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 NEW SECTION. **Sec. 7.** RCW 48.43.035 (Group health benefit plans--
26 Guaranteed issue and continuity of coverage--Exceptions) and 2000 c 79
27 s 24 & 1995 c 265 s 7 are each repealed.

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