
HOUSE BILL 2291

State of Washington 58th Legislature 2003 1st Special
Session

By Representatives Pflug, Benson and Bailey

Read first time . Referred to .

1 AN ACT Relating to access to health insurance for employers and
2 their employees; amending RCW 48.21.045, 48.43.035, 48.43.045,
3 48.44.022, 48.44.023, 48.46.064, and 48.46.066; reenacting and amending
4 RCW 48.43.005; and creating a new section.

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) By January 1, 2004, an insurer offering any health benefit
9 plan to a small employer shall offer and actively market to the small
10 employer a health benefit plan (~~providing benefits identical to the~~
11 ~~schedule of covered health services that are required to be delivered~~
12 ~~to an individual enrolled in the basic health plan)~~ featuring a
13 limited schedule of covered health care services. Nothing in this
14 subsection shall preclude an insurer from offering, or a small employer
15 from purchasing, other health benefit plans that may have more (~~or~~
16 ~~less~~) comprehensive benefits than (~~the basic health plan, provided~~
17 ~~such plans are in accordance with this chapter)~~ those included in the
18 product offered under this subsection. An insurer offering a health
19 benefit plan (~~that does not include benefits in the basic health~~

1 ~~plan))~~ under this subsection shall clearly disclose ~~((these~~
2 ~~differences))~~ all covered benefits to the small employer in a brochure
3 approved by the 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~~
7 ~~subject to the requirements of))~~. The plan may, but is not required
8 to, comply with RCW 48.21.130, ~~((48.21.140, 48.21.141,))~~ 48.21.142,
9 48.21.144, 48.21.146, ~~((48.21.160 through 48.21.197,))~~ 48.21.200,
10 48.21.220, ~~((48.21.225, 48.21.230, 48.21.235,))~~ 48.21.240, 48.21.244,
11 48.21.250, ~~((48.21.300,))~~ 48.21.310, or 48.21.320 ~~((if: (i) The health~~
12 ~~benefit plan is the mandatory offering under (a) of this subsection~~
13 ~~that provides benefits identical to the basic health plan, to the~~
14 ~~extent these requirements differ from the basic health plan; or (ii)~~
15 ~~the health benefit plan is offered to employers with not more than~~
16 ~~twenty five employees))~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 ~~((i))~~ (h) Adjusted community rates established under this section
33 ~~((shall pool the medical experience of all small groups purchasing
34 coverage))~~ may include relativity adjustments, based on deductible
35 leverage, or other actuarially demonstrated differences.

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

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

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

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

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

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

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

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

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

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

33 (b) As used in this section, "adjusted community rate" means the
34 rating method used to establish the premium for health plans adjusted
35 to reflect actuarially demonstrated differences in utilization or cost
36 attributable to geographic area, family size, age, use of wellness
37 activities, industry, and other factors that the commissioner may
38 approve by rule.

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

3 Unless otherwise specifically provided, the definitions in this
4 section apply throughout this chapter.

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

9 (2) "Basic health plan" means the plan described under chapter
10 70.47 RCW, as revised from time to time.

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

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

17 (5) "Catastrophic health plan" means:

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

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

30 (c) Any health benefit plan that provides benefits for hospital
31 inpatient and outpatient services, professional and prescription drugs
32 provided in conjunction with such hospital inpatient and outpatient
33 services, and excludes or substantially limits outpatient physician
34 services and those services usually provided in an office setting.

35 (6) "Certification" means a determination by a review organization
36 that an admission, extension of stay, or other health care service or
37 procedure has been reviewed and, based on the information provided,

1 meets the clinical requirements for medical necessity, appropriateness,
2 level of care, or effectiveness under the auspices of the applicable
3 health benefit plan.

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

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

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

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

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

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

37 (13) "Enrollee point-of-service cost-sharing" means amounts paid to

1 health carriers directly providing services, health care providers, or
2 health care facilities by enrollees and may include copayments,
3 coinsurance, or deductibles.

4 (14) "Grievance" means a written complaint submitted by or on
5 behalf of a covered person regarding: (a) Denial of payment for
6 medical services or nonprovision of medical services included in the
7 covered person's health benefit plan, or (b) service delivery issues
8 other than denial of payment for medical services or nonprovision of
9 medical services, including dissatisfaction with medical care, waiting
10 time for medical services, provider or staff attitude or demeanor, or
11 dissatisfaction with service provided by the health carrier.

12 (15) "Health care facility" or "facility" means hospices licensed
13 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
14 rural health care facilities as defined in RCW 70.175.020, psychiatric
15 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
16 under chapter 18.51 RCW, community mental health centers licensed under
17 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
18 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
19 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
20 facilities licensed under chapter 70.96A RCW, and home health agencies
21 licensed under chapter 70.127 RCW, and includes such facilities if
22 owned and operated by a political subdivision or instrumentality of the
23 state and such other facilities as required by federal law and
24 implementing regulations.

25 (16) "Health care provider" or "provider" means:
26 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
27 practice health or health-related services or otherwise practicing
28 health care services in this state consistent with state law; or
29 (b) An employee or agent of a person described in (a) of this
30 subsection, acting in the course and scope of his or her employment.

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

34 (18) "Health carrier" or "carrier" means a disability insurer
35 regulated under chapter 48.20 or 48.21 RCW, a health care service
36 contractor as defined in RCW 48.44.010, or a health maintenance
37 organization as defined in RCW 48.46.020.

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

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

5 (b) Medicare supplemental health insurance governed by chapter
6 48.66 RCW;

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

9 (d) Disability income;

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

13 (f) Workers' compensation coverage;

14 (g) Accident only coverage;

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

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

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

19 (k) Plans deemed by the insurance commissioner to have a short-term
20 limited purpose or duration, or to be a student-only plan that is
21 guaranteed renewable while the covered person is enrolled as a regular
22 full-time undergraduate or graduate student at an accredited higher
23 education institution, after a written request for such classification
24 by the carrier and subsequent written approval by the insurance
25 commissioner.

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

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

32 (22) "Premium" means all sums charged, received, or deposited by a
33 health carrier as consideration for a health plan or the continuance of
34 a health plan. Any assessment or any "membership," "policy,"
35 "contract," "service," or similar fee or charge made by a health
36 carrier in consideration for a health plan is deemed part of the
37 premium. "Premium" shall not include amounts paid as enrollee point-
38 of-service cost-sharing.

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

6 (24) "Small employer" or "small group" means any person, firm,
7 corporation, partnership, association, political subdivision, sole
8 proprietor, or self-employed individual that is actively engaged in
9 business that, on at least fifty percent of its working days during the
10 preceding calendar quarter, employed at least two but no more than
11 fifty eligible employees, with a normal work week of thirty or more
12 hours, the majority of whom were employed within this state, and is not
13 formed primarily for purposes of buying health insurance and in which
14 a bona fide employer-employee relationship exists. In determining the
15 number of eligible employees, companies that are affiliated companies,
16 or that are eligible to file a combined tax return for purposes of
17 taxation by this state, shall be considered an employer. Subsequent to
18 the issuance of a health plan to a small employer and for the purpose
19 of determining eligibility, the size of a small employer shall be
20 determined annually. Except as otherwise specifically provided, a
21 small employer shall continue to be considered a small employer until
22 the plan anniversary following the date the small employer no longer
23 meets the requirements of this definition. (~~The term "small employer"~~
24 ~~includes a self-employed individual or sole proprietor. The term~~
25 ~~"small employer" also includes a self-employed individual or sole~~
26 ~~proprietor who derives at least seventy five percent of his or her~~
27 ~~income from a trade or business through which the individual or sole~~
28 ~~proprietor has attempted to earn taxable income and for which he or she~~
29 ~~has filed the appropriate internal revenue service form 1040, schedule~~
30 ~~C or F, for the previous taxable year.))~~

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

36 (26) "Wellness activity" means an explicit program of an activity
37 consistent with department of health guidelines, such as, smoking
38 cessation, injury and accident prevention, reduction of alcohol misuse,

1 appropriate weight reduction, exercise, automobile and motorcycle
2 safety, blood cholesterol reduction, and nutrition education for the
3 purpose of improving enrollee health status and reducing health service
4 costs.

5 **Sec. 3.** RCW 48.43.035 and 2000 c 79 s 24 are each amended to read
6 as follows:

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

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

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

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

31 (a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

17 (c) No sooner than January 1, 2004, a carrier discontinues offering
18 a particular type of health benefit plan offered in the small or large
19 group market if: (i) The carrier provides notice to each covered group
20 provided coverage of this type of the discontinuation at least ninety
21 days prior to the date of the discontinuation; (ii) the carrier offers
22 to each group provided coverage of this type the option to enroll, with
23 regard to small groups, in any other small group plan, or with regard
24 to large groups, in any other large group plan, currently being offered
25 by the carrier in the applicable group market; and (iii) in exercising
26 the option to discontinue coverage of this type and in offering the
27 option of coverage under (c)(ii) of this subsection, the carrier acts
28 uniformly without regard to any health status-related factor of
29 enrolled individuals or individuals who may become eligible for this
30 coverage;

31 (d) A carrier discontinues offering all health coverage in the
32 small group market or the large group market, or both markets, in the
33 state and discontinues coverage under all existing group health benefit
34 plans in the large or small group market involved if: (i) The carrier
35 provides notice to the commissioner of its intent to discontinue
36 offering all such coverage in the state and its intent to discontinue
37 coverage under all such existing health benefit plans at least one
38 hundred eighty days prior to the date of the discontinuation of

1 coverage under all such existing health benefit plans; and (ii) the
2 carrier provides notice to each covered group of the intent to
3 discontinue the existing health benefit plan at least one hundred
4 eighty days prior to the date of discontinuation. In the case of
5 discontinuation under this subsection, the carrier may not issue any
6 group health coverage in this state in the group market involved for a
7 five-year period beginning on the date of the discontinuation of the
8 last health benefit plan not so renewed. This subsection (4) does not
9 require a carrier to provide notice to the commissioner of its intent
10 to discontinue offering a health benefit plan to new applicants when
11 the carrier does not discontinue coverage of existing enrollees under
12 that health benefit plan; or

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

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

22 (6) Notwithstanding any other provision of this section, the
23 guarantee of continuity of coverage applies to a group of one only if:
24 (a) The carrier continues to offer the particular plan in which the
25 group of one was enrolled on the day prior to the effective date of
26 this act; and (b) the person continues to qualify as a group of one
27 under the criteria in place on the day prior to the effective date of
28 this act.

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

31 Every individual health plan delivered, issued for delivery, or
32 renewed by a health carrier on and after January 1, 1996, shall:

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

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

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

2 (i) Provision, utilization review, and cost containment of health
3 services;

4 (ii) Management and administrative procedures; and

5 (iii) Provision of cost-effective and clinically efficacious health
6 services.

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

14 **Sec. 5.** RCW 48.44.022 and 2000 c 79 s 30 are each amended to read
15 as follows:

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

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

21 (i) Geographic area;

22 (ii) Family size;

23 (iii) Age;

24 (iv) Tenure discounts; and

25 (v) Wellness activities.

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

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

35 (d) The permitted rates for any age group shall be no more than
36 four hundred twenty-five percent of the lowest rate for all age groups

1 on January 1, 1996, four hundred percent on January 1, 1997, and three
2 hundred seventy-five percent on January 1, 2000, and thereafter.

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

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

9 (i) Changes to the family composition;

10 (ii) Changes to the health benefit plan requested by the
11 individual; or

12 (iii) Changes in government requirements affecting the health
13 benefit plan.

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

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

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

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

30 **Sec. 6.** RCW 48.44.023 and 1995 c 265 s 16 are each amended to read
31 as follows:

32 (1)(a) By January 1, 2004, a health care services contractor
33 offering any health benefit plan to a small employer shall offer and
34 actively market to the small employer a health benefit plan (~~providing~~
35 ~~benefits identical to the schedule of covered health services that are~~
36 ~~required to be delivered to an individual enrolled in the basic health~~
37 ~~plan~~) featuring a limited schedule of covered health care services.

1 Nothing in this subsection shall preclude a contractor from offering,
2 or a small employer from purchasing, other health benefit plans that
3 may have more (~~or less~~) comprehensive benefits than (~~the basic~~
4 ~~health plan, provided such plans are in accordance with this chapter~~)
5 those included in the product offered under this subsection. A
6 contractor offering a health benefit plan (~~that does not include~~
7 ~~benefits in the basic health plan~~) under this subsection shall clearly
8 disclose (~~these differences~~) all covered benefits to the small
9 employer in a brochure approved by the commissioner.

10 (b) A health benefit plan offered under this subsection shall
11 provide coverage for hospital expenses and services rendered by a
12 physician licensed under chapter 18.57 or 18.71 RCW (~~but is not~~
13 ~~subject to the requirements of~~). The plan may, but is not required
14 to, comply with RCW 48.44.225, (~~48.44.240, 48.44.245, 48.44.290,~~
15 ~~48.44.300,~~) 48.44.310, 48.44.320, (~~48.44.325, 48.44.330, 48.44.335,~~)
16 48.44.340, 48.44.344, 48.44.360, 48.44.400, (~~48.44.440,~~) 48.44.450,
17 and 48.44.460 (~~if: (i) The health benefit plan is the mandatory~~
18 ~~offering under (a) of this subsection that provides benefits identical~~
19 ~~to the basic health plan, to the extent these requirements differ from~~
20 ~~the basic health plan; or (ii) the health benefit plan is offered to~~
21 ~~employers with not more than twenty five employees~~)).

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

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

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

33 (i) Geographic area;

34 (ii) Family size;

35 (iii) Age; (~~and~~)

36 (iv) Wellness activities;

37 (v) Industry; and

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

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

5 (c) The contractor shall be permitted to develop separate rates for
6 individuals age sixty-five or older for coverage for which medicare is
7 the primary payer and coverage for which medicare is not the primary
8 payer. Both rates shall be subject to the requirements of this
9 subsection (3).

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

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

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

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

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

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

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

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

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

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

1 may include relativity adjustments, based on deductible leverage, or
2 other actuarially demonstrated differences.

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

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

13 (b) A contractor shall not require a minimum participation level
14 greater than:

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

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

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

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

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

35 (7)(a) As used in this section, "health benefit plan," "small
36 employer," and "wellness activities" mean the same as defined in RCW
37 48.43.005.

1 (b) As used in this section, "adjusted community rate" means the
2 rating method used to establish the premium for health plans adjusted
3 to reflect actuarially demonstrated differences in utilization or cost
4 attributable to geographic area, family size, age, use of wellness
5 activities, industry, and other factors that the commissioner may
6 approve by rule.

7 **Sec. 7.** RCW 48.46.064 and 2000 c 79 s 33 are each amended to read
8 as follows:

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

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

- 14 (i) Geographic area;
- 15 (ii) Family size;
- 16 (iii) Age;
- 17 (iv) Tenure discounts; and
- 18 (v) 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. Individuals under the age
22 of twenty shall be treated as those age twenty.

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

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:

- 1 (i) Changes to the family composition;
2 (ii) Changes to the health benefit plan requested by the
3 individual; or
4 (iii) Changes in government requirements affecting the health
5 benefit plan.

6 (g) For the purposes of this section, a health benefit plan that
7 contains a restricted network provision shall not be considered similar
8 coverage to a health benefit plan that does not contain such a
9 provision, provided that the restrictions of benefits to network
10 providers result in substantial differences in claims costs. This
11 subsection does not restrict or enhance the portability of benefits as
12 provided in RCW 48.43.015.

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

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

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

22 **Sec. 8.** RCW 48.46.066 and 1995 c 265 s 18 are each amended to read
23 as follows:

24 (1)(a) By January 1, 2004, a health maintenance organization
25 offering any health benefit plan to a small employer shall offer and
26 actively market to the small employer a health benefit plan (~~providing~~
27 ~~benefits identical to the schedule of covered health services that are~~
28 ~~required to be delivered to an individual enrolled in the basic health~~
29 ~~plan~~) featuring a limited schedule of covered health care services.
30 Nothing in this subsection shall preclude a health maintenance
31 organization from offering, or a small employer from purchasing, other
32 health benefit plans that may have more (~~or less~~) comprehensive
33 benefits than (~~the basic health plan, provided such plans are in~~
34 ~~accordance with this chapter~~) those included in the product offered
35 under this subsection. A health maintenance organization offering a
36 health benefit plan (~~that does not include benefits in the basic~~

1 ~~health plan))~~ under this subsection shall clearly disclose ~~((these~~
2 ~~differences))~~ all the covered benefits to the small employer in a
3 brochure approved by the 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~~
7 ~~subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285,))~~.
8 The plan may, but is not required to, comply with RCW 48.46.290,
9 ~~((48.46.350, 48.46.355,))~~ 48.46.375, 48.46.440, 48.46.480,
10 ~~((48.46.510,))~~ 48.46.520, and 48.46.530 ~~((if: (i) The health benefit~~
11 ~~plan is the mandatory offering under (a) of this subsection that~~
12 ~~provides benefits identical to the basic health plan, to the extent~~
13 ~~these requirements differ from the basic health plan; or (ii) the~~
14 ~~health benefit plan is offered to employers with not more than twenty-~~
15 ~~five employees))~~.

16 (2) Nothing in this section shall prohibit a health maintenance
17 organization from offering, or a purchaser from seeking, health benefit
18 plans with benefits in excess of the ~~((basic health plan services))~~
19 health benefit plan offered under subsection (1) of this section. All
20 forms, policies, and contracts shall be submitted for approval to the
21 commissioner, and the rates of any plan offered under this section
22 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 health maintenance organization shall develop its rates
26 based on an adjusted community rate and may only vary the adjusted
27 community rate for:

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

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

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

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

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

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

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

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

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

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

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

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

32 ~~((i))~~ (h) Adjusted community rates established under this section
33 ~~((shall pool the medical experience of all groups purchasing coverage))~~
34 may include relativity adjustments, based on deductible leverage, or
35 other actuarially demonstrated differences.

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

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

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

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

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

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

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

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

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

32 (7)(a) As used in this section, "health benefit plan," "small
33 employer," and "wellness activities" mean the same as defined in RCW
34 48.43.005.

35 (b) As used in this section, "adjusted community rate" means the
36 rating method used to establish the premium for health plans adjusted
37 to reflect actuarially demonstrated differences in utilization or cost

1 attributable to geographic area, family size, age, use of wellness
2 activities, industry, and other factors that the commissioner may
3 approve by rule.

4 NEW SECTION. **Sec. 9.** This act applies to all group health benefit
5 plans issued or renewed on or after the effective date of this act.

--- END ---