
ENGROSSED SUBSTITUTE HOUSE BILL 2460

State of Washington

58th Legislature

2004 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Cody, Campbell, Kessler, Morrell, Haigh, Kenney, Santos, Hatfield, Blake, Linville, Upthegrove, Simpson, G., Moeller and Lantz)

READ FIRST TIME 02/06/04.

1 AN ACT Relating to access to health insurance for small employers
2 and their employees; amending RCW 48.21.045, 48.43.018, 48.43.035,
3 48.43.038, 48.44.022, 48.44.023, 48.46.064, and 48.46.066; reenacting
4 and amending RCW 48.43.005; creating a new section; and repealing RCW
5 48.21.260, 48.21.270, 48.44.370, 48.44.380, 48.46.450, and 48.46.460.

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

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

9 (1)(a) An insurer offering any health benefit plan to a small
10 employer (~~shall~~) may offer and actively market to the small employer
11 a health benefit plan (~~providing benefits identical to the schedule of~~
12 ~~covered health services that are required to be delivered to an~~
13 ~~individual enrolled in the basic health plan~~) featuring a limited
14 schedule of covered health care services. Nothing in this subsection
15 shall preclude an insurer from offering, or a small employer from
16 purchasing, other health benefit plans that may have more (~~or less~~)
17 comprehensive benefits than (~~the basic health plan, provided such~~
18 ~~plans are in accordance with this chapter~~) those included in the
19 product offered under this subsection. An insurer offering a health

1 benefit plan (~~that does not include benefits in the basic health~~
2 ~~plan~~) under this subsection shall clearly disclose (~~these~~
3 ~~differences~~) all covered benefits to the small employer in a brochure
4 (~~approved by~~) filed with the commissioner.

5 (b) A health benefit plan offered under this subsection shall
6 provide coverage for hospital expenses and services rendered by a
7 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
8 to the requirements of RCW (~~(48.21.130,)~~) 48.21.140, (~~(48.21.141,)~~)
9 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197,
10 48.21.200, 48.21.220, (~~(48.21.225, 48.21.230, 48.21.235,)~~) 48.21.240,
11 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320 (~~(if: (i) The~~
12 ~~health benefit plan is the mandatory offering under (a) of this~~
13 ~~subsection that provides benefits identical to the basic health plan,~~
14 ~~to the extent these requirements differ from the basic health plan; or~~
15 ~~(ii) the health benefit plan is offered to)~~) for employers with not
16 more than (~~twenty-five~~) fifty 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 (b) The adjustment for age in (a)(iii) of this subsection may not
33 use age brackets smaller than five-year increments, which shall begin
34 with age twenty and end with age sixty-five. Employees under the age
35 of twenty shall be treated as those age twenty.

36 (c) The insurer shall be permitted to develop separate rates for
37 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) The rate charged for a health benefit plan offered under this
12 section may not be adjusted more frequently than annually except that
13 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) Rating factors shall produce premiums for identical groups that
21 differ only by the amounts attributable to plan design, with the
22 exception of discounts for health improvement programs.

23 (h) For the purposes of this section, a health benefit plan that
24 contains a restricted network provision shall not be considered similar
25 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. A carrier
28 may develop its rates based on claims costs due to network provider
29 reimbursement schedules or type of network. This subsection does not
30 restrict or enhance the portability of benefits as provided in RCW
31 48.43.015.

32 (i) Adjusted community rates established under this section shall
33 pool the medical experience of all small groups purchasing coverage
34 including the development of allowable factors under (a) and (h) of
35 this subsection. The development of these factors or benefit
36 relativities must be based on the carrier's company-wide credible study
37 or a large study developed by an actuarial consultant or other method
38 accepted by the commissioner.

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

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

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

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

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

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

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

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

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

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

1 Unless otherwise specifically provided, the definitions in this
2 section apply throughout this chapter.

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

7 (2) "Basic health plan" means the plan described under chapter
8 70.47 RCW, as revised from time to time.

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

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

15 (5) "Catastrophic health plan" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (b) Medicare supplemental health insurance governed by chapter
2 48.66 RCW;

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

5 (d) Disability income;

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

9 (f) Workers' compensation coverage;

10 (g) Accident only coverage;

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

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

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

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

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

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

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

35 (23) "Review organization" means a disability insurer regulated
36 under chapter 48.20 or 48.21 RCW, health care service contractor as
37 defined in RCW 48.44.010, or health maintenance organization as defined

1 in RCW 48.46.020, and entities affiliated with, under contract with, or
2 acting on behalf of a health carrier to perform a utilization review.

3 (24) "Small employer" or "small group" means any person, firm,
4 corporation, partnership, association, political subdivision, sole
5 proprietor, or self-employed individual that is actively engaged in
6 business that, on at least fifty percent of its working days during the
7 preceding calendar quarter, employed at least two but no more than
8 fifty eligible employees, with a normal work week of thirty or more
9 hours, the majority of whom were employed within this state, and is not
10 formed primarily for purposes of buying health insurance and in which
11 a bona fide employer-employee relationship exists. In determining the
12 number of eligible employees, companies that are affiliated companies,
13 or that are eligible to file a combined tax return for purposes of
14 taxation by this state, shall be considered an employer. Subsequent to
15 the issuance of a health plan to a small employer and for the purpose
16 of determining eligibility, the size of a small employer shall be
17 determined annually. Except as otherwise specifically provided, a
18 small employer shall continue to be considered a small employer until
19 the plan anniversary following the date the small employer no longer
20 meets the requirements of this definition. (~~The term "small employer"~~
21 ~~includes a self-employed individual or sole proprietor. The term~~
22 ~~"small employer" also includes a self-employed individual or sole~~
23 ~~proprietor who derives at least seventy five percent of his or her~~
24 ~~income from a trade or business through which the individual or sole~~
25 ~~proprietor has attempted to earn taxable income and for which he or she~~
26 ~~has filed the appropriate internal revenue service form 1040, schedule~~
27 ~~C or F, for the previous taxable year.)) A self-employed individual or
28 sole proprietor who is covered as a group of one on the day prior to
29 the effective date of this section shall also be considered a "small
30 employer" to the extent that individual or group of one is entitled to
31 have his or her coverage renewed as provided in RCW 48.43.035(6).~~

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

37 (26) "Wellness activity" means an explicit program of an activity
38 consistent with department of health guidelines, such as, smoking

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

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

8 (1) Except as provided in (a) through ~~((c))~~ (d) of this
9 subsection, a health carrier may require any person applying for an
10 individual health benefit plan to complete the standard health
11 questionnaire designated under chapter 48.41 RCW.

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

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

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

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

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

31 (c) If a person is seeking an individual health benefit plan due to
32 his or her having exhausted continuation coverage provided under 29
33 U.S.C. Sec. 1161 et seq., or is part of a small employer group of less
34 than twenty employees, and meets the federal standards of eligibility
35 for continuation coverage, completion of the standard health
36 questionnaire shall not be a condition of coverage if application for
37 coverage is made within ninety days of exhaustion of continuation

1 coverage. A health carrier shall accept an application without a
2 standard health questionnaire from a person currently covered by such
3 continuation coverage if application is made within ninety days prior
4 to the date the continuation coverage would be exhausted and the
5 effective date of the individual coverage applied for is the date the
6 continuation coverage would be exhausted, or within ninety days
7 thereafter.

8 (d) If a person is seeking an individual health benefit plan due to
9 his or her receiving notice that his or her coverage under a conversion
10 contract is discontinued, 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 discontinuation of eligibility
13 under the conversion contract. A health carrier shall accept an
14 application without a standard health questionnaire from a person
15 currently covered by such conversion contract if application is made
16 within ninety days prior to the date eligibility under the conversion
17 contract would be discontinued and the effective date of the individual
18 coverage applied for is the date eligibility under the conversion
19 contract would be discontinued, or within ninety days thereafter.

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

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

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

35 (3) If the person applying for an individual health benefit plan:

36 (a) Does not qualify for coverage under the Washington state health
37 insurance pool based upon the results of the standard health
38 questionnaire; (b) does qualify for coverage under the Washington state

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

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

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

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

31 (2) Except as provided in subsection (5) of this section, all
32 health plans shall contain or incorporate by endorsement a guarantee of
33 the continuity of coverage of the plan. For the purposes of this
34 section, a plan is "renewed" when it is continued beyond the earliest
35 date upon which, at the carrier's sole option, the plan could have been
36 terminated for other than nonpayment of premium. The carrier may

1 consider the group's anniversary date as the renewal date for purposes
2 of complying with the provisions of this section.

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

6 (a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (6) Notwithstanding any other provision of this section, the
35 guarantee of continuity of coverage applies to a group of one only if:
36 (a) The carrier continues to offer any other small employer group plan
37 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

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

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

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

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

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

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

8 (i) Geographic area;

9 (ii) Family size;

10 (iii) Age;

11 (iv) Tenure discounts; and

12 (v) 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. Individuals under the age
16 of twenty shall be treated as those age twenty.

17 (c) The health care service contractor 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.

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 family composition;

33 (ii) Changes to the health benefit plan requested by the
34 individual; or

35 (iii) Changes in government requirements affecting the health
36 benefit plan.

37 (g) For the purposes of this section, a health benefit plan that
38 contains a restricted network provision shall not be considered similar

1 coverage to a health benefit plan that does not contain such a
2 provision, provided that the restrictions of benefits to network
3 providers result in substantial differences in claims costs. This
4 subsection does not restrict or enhance the portability of benefits as
5 provided in RCW 48.43.015.

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

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

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

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

17 (1)(a) A health care services contractor offering any health
18 benefit plan to a small employer (~~(shall)~~) may offer and actively
19 market to the small employer a health benefit plan (~~(providing benefits~~
20 ~~identical to the schedule of covered health services that are required~~
21 ~~to be 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,
36 (~~(48.44.290, 48.44.300,)~~) 48.44.310, 48.44.320, (~~(48.44.325, 48.44.330,~~
37 ~~48.44.335,)~~) 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440,

1 48.44.450, and 48.44.460 (~~(if: (i) The health benefit plan is the~~
2 ~~mandatory offering under (a) of this subsection that provides benefits~~
3 ~~identical to the basic health plan, to the extent these requirements~~
4 ~~differ from the basic health plan; or (ii) the health benefit plan is~~
5 ~~offered to)) for employers with not more than (~~(twenty-five))~~ fifty
6 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 this section
13 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 (b) The adjustment for age in (a)(iii) of this subsection may not
23 use age brackets smaller than five-year increments, which shall begin
24 with age twenty and end with age sixty-five. Employees under the age
25 of twenty shall be treated as those age twenty.

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

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

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

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

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

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

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

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

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

13 (h) For the purposes of this section, a health benefit plan that
14 contains a restricted network provision shall not be considered similar
15 coverage to a health benefit plan that does not contain such a
16 provision, provided that the restrictions of benefits to network
17 providers result in substantial differences in claims costs. A carrier
18 may develop its rates based on claims costs due to network provider
19 reimbursement schedules or type of network. This subsection does not
20 restrict or enhance the portability of benefits as provided in RCW
21 48.43.015.

22 (i) Adjusted community rates established under this section shall
23 pool the medical experience of all groups purchasing coverage including
24 the development of allowable factors under (a) and (h) of this
25 subsection. The development of these factors or benefit relativities
26 must be based on the carrier's company-wide credible study or a large
27 study developed by an actuarial consultant or other method accepted by
28 the commissioner.

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 contractor in determining whether to provide coverage to a small
37 employer shall be applied uniformly among all small employers applying
38 for coverage or receiving coverage from the carrier.

1 (b) A contractor shall not require a minimum participation level
2 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 contractor may not increase any requirement for minimum
12 employee participation or modify any requirement for minimum employer
13 contribution applicable to a small employer at any time after the small
14 employer has been accepted for coverage.

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

23 (7) As used in this section, "health benefit plan," "small
24 employer," and "wellness activities" mean the same as defined in RCW
25 48.43.005.

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

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

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

- 33 (i) Geographic area;
- 34 (ii) Family size;
- 35 (iii) Age;
- 36 (iv) Tenure discounts; and
- 37 (v) Wellness activities.

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. Individuals under the age
4 of twenty shall be treated as those age twenty.

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

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

20 (i) Changes to the family composition;

21 (ii) Changes to the health benefit plan requested by the
22 individual; or

23 (iii) Changes in government requirements affecting the health
24 benefit plan.

25 (g) For the purposes of this section, a health benefit plan that
26 contains a restricted network provision shall not be considered similar
27 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 (h) A tenure discount for continuous enrollment in the health plan
33 of two years or more may be offered, not to exceed ten percent.

34 (2) Adjusted community rates established under this section shall
35 pool the medical experience of all individuals purchasing coverage, and
36 shall not be required to be pooled with the medical experience of
37 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~~) may offer and actively
8 market to the small employer a health benefit plan (~~providing benefits~~
9 ~~identical to the schedule of covered health services that are required~~
10 ~~to be delivered to an individual enrolled in the basic health plan~~)
11 featuring a limited schedule of covered health care services. Nothing
12 in this subsection shall preclude a health maintenance organization
13 from offering, or a small employer from purchasing, other health
14 benefit plans that may have more (~~or less~~) comprehensive benefits
15 than (~~the basic health plan, provided such plans are in accordance~~
16 ~~with this chapter~~) those included in the product offered under this
17 subsection. A health maintenance organization 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 the covered benefits to the small employer in a
21 brochure (~~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 (~~48.46.275, 48.46.280, 48.46.285,~~)
26 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480,
27 48.46.510, 48.46.520, and 48.46.530 (~~if: (i) The health benefit plan~~
28 ~~is the mandatory offering under (a) of this subsection that provides~~
29 ~~benefits identical to the basic health plan, to the extent these~~
30 ~~requirements differ from the basic health plan; or (ii) the health~~
31 ~~benefit plan is offered to~~) for employers with not more than (~~twenty-~~
32 ~~five~~) fifty employees.

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

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

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

13 (i) Adjusted community rates established under this section shall
14 pool the medical experience of all groups purchasing coverage including
15 the development of allowable factors under (a) and (h) of this
16 subsection. The development of these factors or benefit relativities
17 must be based on the carrier's company-wide credible study or a large
18 study developed by an actuarial consultant or other method accepted by
19 the commissioner.

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

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

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

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

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

36 (c) In applying minimum participation requirements with respect to
37 a small employer, a small employer shall not consider employees or

1 dependents who have similar existing coverage in determining whether
2 the applicable percentage of participation is met.

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

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

17 (7) As used in this section, "health benefit plan," "small
18 employer," and "wellness activities" mean the same as defined in RCW
19 48.43.005.

20 NEW SECTION. Sec. 10. The following acts or parts of acts are
21 each repealed:

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

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

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

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

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

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

34 NEW SECTION. Sec. 11. Sections 1 through 9 of this act apply to

1 all small group health benefit plans issued or renewed on or after the
2 effective date of this section.

--- END ---