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HOUSE BILL 2460

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By Representatives Cody, Campbell, Kessler, Morrell, Haigh, Kenney, Santos, Hatfield, Blake, Linville, Upthegrove, Simpson, G., Moeller and Lantz

Read first time 01/14/2004. Referred to Committee on Health Care.

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 48.43.045, 48.44.022, 48.44.023, 48.46.064, and 48.46.066; reenacting  
4 and amending RCW 48.43.005; adding new sections to chapter 48.43 RCW;  
5 adding a new chapter to Title 48 RCW; creating a new section; repealing  
6 RCW 48.21.250, 48.44.360, and 48.46.440; and providing an effective  
7 date.

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

9 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW  
10 to read as follows:

11 (1) To increase health benefit plan options available to small  
12 employers in Washington state, the commissioner may approve  
13 applications from carriers to offer health benefit plans that do not  
14 include all services currently mandated in chapters 48.21, 48.44, and  
15 48.46 RCW. A waiver granted by the commissioner must meet the  
16 following criteria:

17 (a) The commissioner may not waive service mandates for maternity-  
18 related services or clinical preventive services recommended by the  
19 United States public health service;

1 (b) Any health benefit plan provided through the waiver authority  
2 granted in this section must clearly delineate to small employers those  
3 health services that are included in the plan, and those mandated  
4 services that will not be offered as a result of the waiver;

5 (c) The duration of a waiver may not exceed five years; and

6 (d) Any carrier who receives a waiver must agree to provide  
7 information requested by the commissioner needed to meet the reporting  
8 requirement under subsection (3) of this section.

9 (2) The commissioner shall approve at least two waiver applications  
10 from carriers on or before January 1, 2005, to the extent that a  
11 carrier or carriers have submitted applications for waivers that meet  
12 the requirements of this section.

13 (3) On or before November 1, 2008, the commissioner shall submit a  
14 report to the legislature that includes:

15 (a) A description of the waivers granted under this section to  
16 date;

17 (b) Data on the extent to which the health benefit plans offered  
18 under this section have been purchased by small employers; and

19 (c) The impact, if any, upon the small group health insurance  
20 market in Washington state, including, but not limited to, information  
21 on newly admitted carriers who are offering health benefit plans  
22 approved under this section, and any evidence of increased risk  
23 segmentation in the small group market as a result of the offering of  
24 health benefit plans approved under this section.

25 **Sec. 2.** RCW 48.21.045 and 1995 c 265 s 14 are each amended to read  
26 as follows:

27 (1)(a) Upon approval of the commissioner as provided in section 1  
28 of this act, an insurer offering any health benefit plan to a small  
29 employer shall offer and actively market to the small employer a health  
30 benefit plan (~~providing benefits identical to the schedule of covered~~  
31 health services that are required to be delivered to an individual  
32 enrolled in the basic health plan)) featuring a limited schedule of  
33 covered health care services. Nothing in this subsection shall  
34 preclude an insurer from offering, or a small employer from purchasing,  
35 other health benefit plans that may have more (~~or less~~) comprehensive  
36 benefits than (~~the basic health plan, provided such plans are in~~  
37 ~~accordance with this chapter~~) those included in the product offered

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

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

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

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

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

- 29 (i) Geographic area;
- 30 (ii) Family size;
- 31 (iii) Age; and
- 32 (iv) Wellness activities.

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

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

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

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

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

11 (f) 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. This  
28 subsection does not restrict or enhance the portability of benefits as  
29 provided in RCW 48.43.015.

30 (i) Adjusted community rates established under this section shall  
31 pool the medical experience of all small groups purchasing coverage.  
32 However, the adjusted community rates may vary based upon actuarially  
33 demonstrated differences.

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

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

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

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

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

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

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

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

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

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

32 **Sec. 3.** RCW 48.43.005 and 2001 c 196 s 5 and 2001 c 147 s 1 are  
33 each reenacted and amended to read as follows:

34 Unless otherwise specifically provided, the definitions in this  
35 section apply throughout this chapter.

36 (1) "Adjusted community rate" means the rating method used to

1 establish the premium for health plans adjusted to reflect actuarially  
2 demonstrated differences in utilization or cost attributable to  
3 geographic region, age, family size, and use of wellness activities.

4 (2) "Basic health plan" means the plan described under chapter  
5 70.47 RCW, as revised from time to time.

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

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

12 (5) "Catastrophic health plan" means:

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

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

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

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

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

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

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

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

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

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

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

36 (14) "Grievance" means a written complaint submitted by or on  
37 behalf of a covered person regarding: (a) Denial of payment for  
38 medical services or nonprovision of medical services included in the

1 covered person's health benefit plan, or (b) service delivery issues  
2 other than denial of payment for medical services or nonprovision of  
3 medical services, including dissatisfaction with medical care, waiting  
4 time for medical services, provider or staff attitude or demeanor, or  
5 dissatisfaction with service provided by the health carrier.

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

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

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

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

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

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

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

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

36 (b) Medicare supplemental health insurance governed by chapter  
37 48.66 RCW;



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

3 (d) Disability income;

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

7 (f) Workers' compensation coverage;

8 (g) Accident only coverage;

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

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

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

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

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

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

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

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

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

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

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

1 safety, blood cholesterol reduction, and nutrition education for the  
2 purpose of improving enrollee health status and reducing health service  
3 costs.

4 **Sec. 4.** RCW 48.43.018 and 2001 c 196 s 8 are each amended to read  
5 as follows:

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

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

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

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

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

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

29 (c) If a person is seeking an individual health benefit plan due to  
30 his or her having exhausted continuation coverage provided under 29  
31 U.S.C. Sec. 1161 et seq., or sections 13 through 19 of this act,  
32 completion of the standard health questionnaire shall not be a  
33 condition of coverage if application for coverage is made within ninety  
34 days of exhaustion of continuation coverage. A health carrier shall  
35 accept an application without a standard health questionnaire from a  
36 person currently covered by such continuation coverage if application  
37 is made within ninety days prior to the date the continuation coverage

1 would be exhausted and the effective date of the individual coverage  
2 applied for is the date the continuation coverage would be exhausted,  
3 or within ninety days thereafter.

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

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

9 (b) Within fifteen business days of receipt of a completed  
10 application, the carrier shall provide written notice of the decision  
11 not to accept the person's application for enrollment to both the  
12 person and the administrator of the Washington state health insurance  
13 pool. The notice to the person shall state that the person is eligible  
14 for health insurance provided by the Washington state health insurance  
15 pool, and shall include information about the Washington state health  
16 insurance pool and an application for such coverage. If the carrier  
17 does not provide or postmark such notice within fifteen business days,  
18 the application is deemed approved.

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

20 (a) Does not qualify for coverage under the Washington state health  
21 insurance pool based upon the results of the standard health  
22 questionnaire; (b) does qualify for coverage under the Washington state  
23 health insurance pool based upon the results of the standard health  
24 questionnaire and the carrier elects to accept the person for  
25 enrollment; or (c) is not required to complete the standard health  
26 questionnaire designated under this chapter under subsection (1)(a) or  
27 (b) of this section, the carrier shall accept the person for enrollment  
28 if he or she resides within the carrier's service area and provide or  
29 assure the provision of all covered services regardless of age, sex,  
30 family structure, ethnicity, race, health condition, geographic  
31 location, employment status, socioeconomic status, other condition or  
32 situation, or the provisions of RCW 49.60.174(2). The commissioner may  
33 grant a temporary exemption from this subsection if, upon application  
34 by a health carrier, the commissioner finds that the clinical,  
35 financial, or administrative capacity to serve existing enrollees will  
36 be impaired if a health carrier is required to continue enrollment of  
37 additional eligible individuals.

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

3        Beginning January 1, 2005, any carrier offering health benefit  
4 plans to small employers under the waiver authority established in  
5 section 1 of this act must offer and actively market to small employers  
6 at least three other plans of the carrier's choosing. However, this  
7 requirement does not apply to newly admitted carriers who offer a  
8 health benefit plan to small employers under the waiver authority  
9 established in section 1 of this act for the period of the waiver.  
10 This section does not limit the ability of a carrier to offer small  
11 employer group health benefit plans subject to all requirements  
12 applicable to health benefit plans offered under this chapter in  
13 addition to those that must be offered through a waiver.

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

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

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

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

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

4 (a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

27 (c) No sooner than January 1, 2005, a carrier discontinues offering  
28 a particular type of health benefit plan offered in the small group  
29 market if: (i) The carrier provides notice to each covered group  
30 provided coverage of this type of the discontinuation at least ninety  
31 days prior to the date of the discontinuation; (ii) the carrier offers  
32 to each group provided coverage of this type the option to enroll, with  
33 regard to small groups, in any other small group plan currently being  
34 offered by the carrier in the applicable group market; and (iii) in  
35 exercising the option to discontinue coverage of this type and in  
36 offering the option of coverage under (c)(ii) of this subsection, the  
37 carrier acts uniformly without regard to any health status-related

1 factor of enrolled individuals or individuals who may become eligible  
2 for this coverage;

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

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

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

31 (6) Notwithstanding any other provision of this section, the  
32 guarantee of continuity of coverage applies to a group of one only if:  
33 (a) The carrier continues to offer any other small group plan in which  
34 the group of one was eligible to enroll in on the day prior to the  
35 effective date of this section; and (b) the person continues to qualify  
36 as a group of one under the criteria in place on the day prior to the  
37 effective date of this section.

1       **Sec. 7.** RCW 48.43.045 and 1997 c 231 s 205 are each amended to  
2 read as follows:

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

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

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

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

11       (i) Provision, utilization review, including prior authorization  
12 and visitation limits, and cost containment of health services;

13       (ii) Management and administrative procedures; and

14       (iii) Provision of cost-effective and clinically efficacious health  
15 services.

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

23       **Sec. 8.** RCW 48.44.022 and 2000 c 79 s 30 are each amended to read  
24 as follows:

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

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

30       (i) Geographic area;

31       (ii) Family size;

32       (iii) Age;

33       (iv) Tenure discounts; and

34       (v) Wellness activities.

35       (b) The adjustment for age in (a)(iii) of this subsection may not  
36 use age brackets smaller than five-year increments which shall begin



1 with age twenty and end with age sixty-five. Individuals under the age  
2 of twenty shall be treated as those age twenty.

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

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

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

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

18 (i) Changes to the family composition;

19 (ii) Changes to the health benefit plan requested by the  
20 individual; or

21 (iii) Changes in government requirements affecting the health  
22 benefit plan.

23 (g) 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. This  
28 subsection does not restrict or enhance the portability of benefits as  
29 provided in RCW 48.43.015.

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

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

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

1       **Sec. 9.** RCW 48.44.023 and 1995 c 265 s 16 are each amended to read  
2 as follows:

3       (1)(a) Upon approval of the commissioner as provided in section 1  
4 of this act, a health care services contractor offering any health  
5 benefit plan to a small employer shall offer and actively market to the  
6 small employer a health benefit plan (~~providing benefits identical to~~  
7 ~~the schedule of covered health services that are required to be~~  
8 ~~delivered to an individual enrolled in the basic health plan)~~  
9 featuring a limited schedule of covered health care services. Nothing  
10 in this subsection shall preclude a contractor from offering, or a  
11 small employer from purchasing, other health benefit plans that may  
12 have more (~~or less~~) comprehensive benefits than (~~the basic health~~  
13 ~~plan, provided such plans are in accordance with this chapter~~) those  
14 included in the product offered under this subsection. A contractor  
15 offering a health benefit plan (~~that does not include benefits in the~~  
16 ~~basic health plan~~) under this subsection shall clearly disclose  
17 (~~these differences~~) all covered benefits to the small employer in a  
18 brochure approved by the commissioner.

19       (b) A health benefit plan offered under this subsection shall  
20 (~~provide coverage for hospital expenses and services rendered by a~~  
21 ~~physician licensed under chapter 18.57 or 18.71 RCW but is not subject~~  
22 ~~to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,~~  
23 ~~48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,~~  
24 ~~48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and~~  
25 ~~48.44.460 if:~~ (i) The health benefit plan is the mandatory offering  
26 under (a) of this subsection that provides benefits identical to the  
27 basic health plan, to the extent these requirements differ from the  
28 basic health plan; or (ii) the health benefit plan is offered) be  
29 limited to employers with not more than (~~twenty-five~~) fifty  
30 employees.

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

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

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

- 5 (i) Geographic area;
- 6 (ii) Family size;
- 7 (iii) Age; and
- 8 (iv) Wellness activities.

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

13 (c) The contractor shall be permitted to develop separate rates for  
14 individuals age sixty-five or older for coverage for which medicare is  
15 the primary payer and coverage for which medicare is not the primary  
16 payer. Both rates shall be subject to the requirements of this  
17 subsection (3).

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

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

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

- 28 (i) Changes to the enrollment of the small employer;
- 29 (ii) Changes to the family composition of the employee;
- 30 (iii) Changes to the health benefit plan requested by the small  
31 employer; or
- 32 (iv) Changes in government requirements affecting the health  
33 benefit plan.

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

37 (h) 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 (i) Adjusted community rates established under this section shall  
7 pool the medical experience of all groups purchasing coverage.  
8 However, the adjusted community rates may vary based upon actuarially  
9 demonstrated differences.

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

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

20 (b) A contractor shall not require a minimum participation level  
21 greater than:

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

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

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

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

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

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

4 (7) As used in this section, "health benefit plan," "small  
5 employer," and "wellness activities" mean the same as defined in RCW  
6 48.43.005.

7 **Sec. 10.** 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. 11.** RCW 48.46.066 and 1995 c 265 s 18 are each amended to  
23 read as follows:

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

1 ~~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 subject~~  
7 ~~to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290,~~  
8 ~~48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510,~~  
9 ~~48.46.520, and 48.46.530 if: (i) The health benefit plan is the~~  
10 ~~mandatory offering under (a) of this subsection that provides benefits~~  
11 ~~identical to the basic health plan, to the extent these requirements~~  
12 ~~differ from the basic health plan; or (ii) the health benefit plan is~~  
13 ~~offered))~~ be limited to employers with not more than ~~((twenty-five))~~  
14 fifty employees.

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

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

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

- 27 (i) Geographic area;
- 28 (ii) Family size;
- 29 (iii) Age; and
- 30 (iv) Wellness activities.

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

35 (c) The health maintenance organization shall be permitted to  
36 develop separate rates for individuals age sixty-five or older for  
37 coverage for which medicare is the primary payer and coverage for which

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

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

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

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

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

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

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

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

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

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

29 (i) Adjusted community rates established under this section shall  
30 pool the medical experience of all groups purchasing coverage.  
31 However, the adjusted community rates may vary based upon actuarially  
32 demonstrated differences.

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



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

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

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

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

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

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

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

29 (7) As used in this section, "health benefit plan," "small  
30 employer," and "wellness activities" mean the same as defined in RCW  
31 48.43.005.

32 NEW SECTION. Sec. 12. Sections 1 through 11 of this act apply to  
33 all small group health benefit plans issued or renewed on or after the  
34 effective date of this section.

35 NEW SECTION. Sec. 13. The definitions in this section apply  
36 throughout this chapter unless the context clearly requires otherwise.

1 (1) "Applicable premium" means, with respect to any period of  
2 continuation of coverage for qualified beneficiaries, the premium  
3 charged by the group health plan for that period of coverage for  
4 beneficiaries with respect to whom a qualifying event has not occurred,  
5 regardless of whether the premium is paid by the employer or employee.

6 (2) "Carrier" means the carrier, as defined in RCW 48.43.005, that  
7 issued the small employer's group health plan.

8 (3) "Continuation coverage" means coverage under the group health  
9 plan that meets the requirements of section 15 of this act.

10 (4) "Covered employee" means an employee who is or was provided  
11 coverage under a group health plan by virtue of the individual's  
12 employment or previous employment with a small employer.

13 (5) "Group health plan" means any health benefit plan, as defined  
14 in RCW 48.43.005, maintained by a small employer, that provides health  
15 care benefit coverage for the employer's employees or former employees,  
16 or for the dependents of those employees or former employees.

17 (6) "Qualified beneficiary" means any individual who, on the day  
18 before the qualifying event for the covered employee, is a beneficiary  
19 under the group health plan by virtue of the individual being:

20 (a) The covered employee, except if the employee is terminated for  
21 gross misconduct. The employer's decision to terminate for gross  
22 misconduct is conclusive as to the carrier;

23 (b) The spouse of the covered employee; or

24 (c) The dependent child of the covered employee.

25 (7) "Qualifying event" means, with respect to any covered employee,  
26 any of the following events which, but for the election of continuation  
27 coverage, would result in a loss of coverage to a qualified  
28 beneficiary:

29 (a) The death of the covered employee;

30 (b) The termination or reduction of hours of the covered employee's  
31 employment, except that termination of an employee for gross misconduct  
32 does not constitute a qualifying event. The employer's decision to  
33 terminate for gross misconduct is conclusive as to the carrier;

34 (c) The divorce or legal separation of the covered employee from  
35 the covered employee's spouse;

36 (d) A covered employee becoming entitled to benefits under either  
37 part A or part B of Title XVIII of the Social Security Act (Medicare);

1 (e) A dependent child ceasing to be a dependent child under the  
2 generally applicable requirements of the group health plan; or

3 (f) A retiree or the spouse or child of a retiree losing coverage  
4 within one year before or after commencement of a bankruptcy proceeding  
5 under Title XI of the United States Code by the employer from whose  
6 employment the covered employee retired.

7 (8) "Small employer" means a small employer as defined in RCW  
8 48.43.005, who for purposes of this chapter employs fewer than twenty  
9 employees.

10 NEW SECTION. **Sec. 14.** A group health plan issued to a small  
11 employer must provide that each qualified beneficiary who would lose  
12 coverage under the group health plan because of a qualifying event is  
13 entitled, without evidence of insurability, to elect, within the  
14 election period provided in section 15 of this act, continuation  
15 coverage under the employer's group health plan. A qualified  
16 beneficiary who elects continuation coverage is subject to all the  
17 terms and conditions applicable under the group health plan.

18 NEW SECTION. **Sec. 15.** (1) Continuation coverage under the group  
19 health plan must, at a minimum, extend for the period beginning on the  
20 date of the qualifying event and ending not earlier than the earliest  
21 of the following:

22 (a) The date that is eighteen months after the date on which the  
23 qualified beneficiary's benefits under the group health plan would  
24 otherwise have ceased because of a qualifying event;

25 (b) The date on which coverage ceases under the group health plan  
26 by reason of a failure to make timely payment of the applicable premium  
27 with respect to any qualified beneficiary;

28 (c) The date a qualified beneficiary becomes covered under any  
29 other group health plan, if the qualified beneficiary will not be  
30 subject to any exclusion or limitation because of a preexisting  
31 condition of that beneficiary;

32 (d) The date a qualified beneficiary is entitled to benefits under  
33 either part A or part B of Title XVIII of the Social Security Act  
34 (Medicare); or

35 (e) The date on which the employer terminates coverage under the  
36 group health plan for all employees. If the employer terminates

1 coverage under the group health plan for all employees and if that  
2 group health plan is replaced by similar coverage under another group  
3 health plan, the qualified beneficiary has the right to become covered  
4 under the new group health plan for the balance of the period that she  
5 or he would have remained covered under the prior group health plan.  
6 A qualified beneficiary is to be treated in the same manner as an  
7 active beneficiary for whom a qualifying event has not taken place.

8 (2) A qualified beneficiary who is determined, under Title II or  
9 Title XVI of the Social Security Act, to have been disabled at the time  
10 of a qualifying event, may be eligible to continue coverage for an  
11 additional eighteen months, for a total of thirty-six months, if the  
12 qualified beneficiary provides the written determination of disability  
13 from the Social Security Administration to the insurance carrier within  
14 sixty days of the date of determination of disability by the Social  
15 Security Administration and prior to the end of the eighteen-month  
16 continuation period. The insurance carrier can charge up to one  
17 hundred fifty percent of the group rate during the eighteen-month  
18 disability extension. The qualified beneficiary must notify the  
19 insurance carrier within thirty days upon the determination that the  
20 qualified beneficiary is no longer disabled under Title II or Title XVI  
21 of the Social Security Act.

22 NEW SECTION. **Sec. 16.** (1) A qualified beneficiary must give  
23 written notice to the insurance carrier within thirty days after the  
24 occurrence of a qualifying event. Unless otherwise specified in the  
25 notice, a notice by any qualified beneficiary constitutes notice on  
26 behalf of all qualified beneficiaries. The written notice must inform  
27 the insurance carrier of the occurrence and type of the qualifying  
28 event giving rise to the potential election by a qualified beneficiary  
29 of continuation of coverage under the group health plan issued by that  
30 insurance carrier, except that in cases where the covered employee has  
31 been involuntarily discharged, the nature of the discharge need not be  
32 disclosed. The written notice must, at a minimum, identify the  
33 employer, the group health plan number, the name and address of all  
34 qualified beneficiaries, and other information required by the  
35 insurance carrier under the terms of the group health plan or the  
36 commissioner by rule, to the extent that this information is known by  
37 the qualified beneficiary.

1 (2) Within fourteen days after the receipt of written notice under  
2 subsection (1) of this section, the insurance carrier shall send each  
3 qualified beneficiary by certified mail an election and premium notice  
4 form, approved by the insurance commissioner, that provides for the  
5 qualified beneficiary's election or nonelection of continuation of  
6 coverage under the group health plan and the applicable premium amount  
7 due after the election to continue coverage. This subsection does not  
8 require separate mailing of notices to qualified beneficiaries residing  
9 in the same household, but requires a separate mailing for each  
10 separate household.

11 (3) A covered employee or other qualified beneficiary who wishes  
12 continuation of coverage must pay the initial premium and elect  
13 continuation in writing to the insurance carrier issuing the employer's  
14 group health plan within thirty days after receiving notice from the  
15 insurance carrier under subsection (2) of this section. Subsequent  
16 premiums are due by the grace period expiration date. The insurance  
17 carrier or the insurance carrier's designee shall process all elections  
18 promptly and provide coverage retroactively to the date coverage would  
19 otherwise have terminated. The premium due shall be for the period  
20 beginning on the date coverage would have otherwise terminated due to  
21 the qualifying event. The first premium payment must include the  
22 coverage paid to the end of the month in which the first payment is  
23 made. After the election, the insurance carrier must bill the  
24 qualified beneficiary for premiums once each month, with a due date on  
25 the first of the month of coverage and allowing a thirty-day grace  
26 period for payment.

27 (4) Except as otherwise specified in an election, any election by  
28 a qualified beneficiary is deemed to include an election of  
29 continuation of coverage on behalf of any other qualified beneficiary  
30 residing in the same household who would lose coverage under the group  
31 health plan by reason of a qualifying event. This subsection does not  
32 preclude a qualified beneficiary from electing continuation of coverage  
33 on behalf of any other qualified beneficiary.

34 (5) The premium paid for continuation of coverage may not exceed  
35 one hundred ten percent of the applicable premium.

36 (6) If an insurance carrier fails to comply with the notice  
37 requirements of subsection (2) of this section, and noncompliance  
38 results in the failure of an eligible qualified beneficiary to elect

1 continuation under the group health plan, the qualified beneficiary is  
2 deemed to have timely elected continuation of coverage within the  
3 election period and shall be covered under the group health plan at the  
4 expense of the noncomplying insurance carrier. The liability exposure  
5 of a noncomplying insurance carrier under this subsection shall be  
6 limited to the period that includes the effective date of coverage  
7 pursuant to an affirmative election through the date on which the  
8 qualified beneficiary receives actual notice. This subsection does not  
9 apply to the extent that the failure of the insurance carrier to comply  
10 with applicable notice requirements was due to noncompliance by the  
11 qualified beneficiary with notice requirements applicable to the  
12 qualified beneficiary.

13 NEW SECTION. **Sec. 17.** (1) Any group health plan issued to or  
14 renewed by a small employer on or after January 1, 2005, must include  
15 a notification of the right to continue coverage as provided by this  
16 chapter, and the procedures for requesting continuation in each policy,  
17 contract, and certificate of coverage and in the plan booklet. The  
18 plan booklet must also contain all information necessary for a  
19 qualified beneficiary to comply with the notice requirements of section  
20 5 of this act, and must contain a form for the notices.

21 (2) The insurance carrier shall mail an initial notice to each  
22 covered employee, covered spouse, and covered dependent describing  
23 their rights under this section. A mailing to one household  
24 constitutes a mailing to all covered persons residing in that  
25 household. A separate mailing is required for each separate household.

26 NEW SECTION. **Sec. 18.** This chapter does not apply if continuation  
27 of coverage benefits are available to covered employees or other  
28 qualified beneficiaries pursuant to section 4980B of the Internal  
29 Revenue Code; Chapter 18 of the Employee Retirement Income Security  
30 Act, 29 U.S.C. Sec. 1161 et seq.; or Chapter 6A of the Public Health  
31 Service Act, 42 U.S.C. Sec. 300bb-1 et seq.

32 NEW SECTION. **Sec. 19.** The insurance commissioner shall adopt  
33 rules establishing standards for the initial notice of rights and as  
34 otherwise necessary to administer this chapter.

1        NEW SECTION.    **Sec. 20.**    The following acts or parts of acts are  
2 each repealed:

3        (1) RCW 48.21.250 (Continuation option to be offered) and 1984 c  
4 190 s 2;

5        (2) RCW 48.44.360 (Continuation option to be offered) and 1984 c  
6 190 s 5; and

7        (3) RCW 48.46.440 (Continuation option to be offered) and 1984 c  
8 190 s 8.

9        NEW SECTION.    **Sec. 21.**    Sections 13 through 19 of this act  
10 constitute a new chapter in Title 48 RCW.

11        NEW SECTION.    **Sec. 22.**    Sections 13 through 19 of this act take  
12 effect January 1, 2005.

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