H-3792.3

# HOUSE BILL 2460

**State of Washington 58th Legislature 2004 Regular Session**

**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.

AN ACT Relating to access to health insurance for small employers and their employees; amending RCW 48.21.045, 48.43.018, 48.43.035, 48.43.045, 48.44.022, 48.44.023, 48.46.064, and 48.46.066; reenacting and amending RCW 48.43.005; adding new sections to chapter 48.43 RCW; adding a new chapter to Title 48 RCW; creating a new section; repealing RCW 48.21.250, 48.44.360, and 48.46.440; and providing an effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) "Catastrophic health plan" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For group health benefit plans, the following shall apply:

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

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

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

(a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Provision, utilization review, <u>including prior authorization and visitation limits,</u> and cost containment of health services;

(ii) Management and administrative procedures; and

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

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

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Sec. 10.** RCW 48.46.064 and 2000 c 79 s 33 are each amended to read as follows:

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

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

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

~~plan~~)) under this subsection shall clearly disclose ((~~these differences~~)) all the covered benefits to the small employer in a brochure approved by the commissioner.

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

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

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. <u>However, the adjusted community rates may vary based upon actuarially demonstrated differences.</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The spouse of the covered employee; or

(c) The dependent child of the covered employee.

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

(a) The death of the covered employee;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**--- END ---**