

2SSB 5945 - H AMD 607

By Representative Ericksen

SCOPE AND OBJECT 04/16/2009

1 Strike everything after the enacting clause and insert the  
2 following:

3 "NEW SECTION. **Sec. 1.** (1) The legislature finds that:

4 (a) In January 2007 the blue ribbon commission on health care costs  
5 and access issued its report, which included a recommendation to give  
6 individuals and families more choice in selecting private insurance  
7 plans that work for them. This recommendation specifically stated,  
8 "Washington needs a multipronged approach to tackle the challenges  
9 facing our uninsured population. Over half of Washington's total  
10 uninsured population consists of young adults ages nineteen to thirty-  
11 four. In addition, fifty thousand are employees of small businesses  
12 who have incomes in excess of two hundred percent of the federal  
13 poverty level. Providing these and other individuals affordable  
14 insurance options on the private market will go a long way in  
15 decreasing the number of uninsured in the state."

16 (b) In the 2007 legislative session, Engrossed Second Substitute  
17 Senate Bill No. 5930 titled "an act relating to providing high quality,  
18 affordable health care to Washingtonians based on the recommendations  
19 of the blue ribbon commission on health care costs and access" was  
20 introduced and passed without any provisions related to the  
21 recommendation described in this section.

22 (c) State budget cuts to existing government health care programs  
23 such as the basic health plan, general assistance unemployable, and  
24 medicaid demonstrate the unsustainability of government health care  
25 programs and the need to reform the private health insurance market  
26 instead of expanding government health care programs which are intended  
27 to be safety net programs for our most vulnerable citizens.

28 (2) The legislature intends to:

29 (a) Implement the recommendation of the blue ribbon commission on  
30 health care costs and access, and implement a multipronged approach

1 that provides more affordable health insurance options in the private  
2 health insurance market to decrease the number of uninsured in  
3 Washington; and

4 (b) Establish a Washington health partnership advisory group to  
5 review progress on the implementation of reforms to the private health  
6 insurance market and recommend any additional reforms needed to provide  
7 affordable health insurance options for all Washingtonians.

8 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.06 RCW  
9 to read as follows:

10 (1) Beginning October 1, 2010, the governor shall convene annual  
11 meetings of a Washington health partnership advisory group. The  
12 advisory group must review progress on the implementation of this act  
13 to give individuals and employers more choice in selecting private  
14 insurance plans that work for them. The advisory group shall also  
15 provide input related to further actions that can be taken to reform  
16 the private health insurance market so that it has affordable health  
17 insurance options for all Washingtonians.

18 (2) The membership of the advisory group shall include:

19 (a) Two members of the house of representatives and two members of  
20 the senate, representing the majority and minority caucuses of each  
21 body;

22 (b) The insurance commissioner;

23 (c) The secretary of the department of social and health services,  
24 the administrator of the health care authority, and the director of the  
25 office of financial management;

26 (d) Members of the forum and the Puget Sound health alliance;

27 (e) Health insurance carriers who currently offer plans in  
28 Washington state, and out-of-state carriers interested in offering  
29 plans in Washington state; and

30 (f) Employer and consumer representatives.

31 **Sec. 3.** RCW 48.21.045 and 2008 c 143 s 6 are each amended to read  
32 as follows:

33 (1)((~~a~~)) An insurer offering any health benefit plan to a small  
34 employer, either directly or through an association or member-governed  
35 group formed specifically for the purpose of purchasing health care,  
36 may offer and actively market to the small employer a health benefit

1 plan featuring a limited schedule of covered health care services.  
2 ~~((Nothing in this subsection shall preclude an insurer from offering,~~  
3 ~~or a small employer from purchasing, other health benefit plans that~~  
4 ~~may have more comprehensive benefits than those included in the product~~  
5 ~~offered under this subsection. An insurer offering a health benefit~~  
6 ~~plan under this subsection shall clearly disclose all covered benefits~~  
7 ~~to the small employer in a brochure filed with the commissioner.~~

8 ~~(b) A health benefit plan offered under this subsection shall~~  
9 ~~provide coverage for hospital expenses and services rendered by a~~  
10 ~~physician licensed under chapter 18.57 or 18.71 RCW but is not subject~~  
11 ~~to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,~~  
12 ~~48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,~~  
13 ~~48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250,~~  
14 ~~48.21.300, 48.21.310, or 48.21.320.~~

15 ~~(2))~~ (a) The plan offered under this subsection may be offered  
16 with a choice of cost-sharing arrangements, and may, but is not  
17 required to, comply with: RCW 48.21.130 through 48.21.241, 48.21.244  
18 through 48.21.280, 48.21.300 through 48.21.320, 48.43.045(1) except as  
19 required in (b) of this subsection, 48.43.093, 48.43.115 through  
20 48.43.185, 48.43.515(5), or 48.42.100.

21 (b) In offering the plan under this subsection, the insurer must  
22 offer the small employer the option of permitting every category of  
23 health care provider to provide health services or care for conditions  
24 covered by the plan pursuant to RCW 48.43.045(1).

25 (2) An insurer offering the plan under subsection (1) of this  
26 section must also offer and actively market to the small employer at  
27 least one additional health benefit plan.

28 (3) Nothing in this section shall prohibit an insurer from  
29 offering, or a purchaser from seeking, health benefit plans with  
30 benefits in excess of the health benefit plan offered under subsection  
31 (1) of this section. All forms, policies, and contracts shall be  
32 submitted for approval to the commissioner, and the rates of any plan  
33 offered under this section shall be reasonable in relation to the  
34 benefits thereto.

35 ~~((3))~~ (4) Premium rates for health benefit plans for small  
36 employers as defined in this section shall be subject to the following  
37 provisions:

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

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

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

11 (c) The insurer shall be permitted to develop separate rates for  
12 individuals age sixty-five or older for coverage for which medicare is  
13 the primary payer and coverage for which medicare is not the primary  
14 payer. Both rates shall be subject to the requirements of this  
15 subsection (~~((+3))~~) (4).

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

20 (e) A discount for wellness activities shall be permitted to  
21 reflect actuarially justified differences in utilization or cost  
22 attributed to such programs.

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

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

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

35 (h) For the purposes of this section, a health benefit plan that  
36 contains a restricted network provision shall not be considered similar  
37 coverage to a health benefit plan that does not contain such a  
38 provision, provided that the restrictions of benefits to network

1 providers result in substantial differences in claims costs. A carrier  
2 may develop its rates based on claims costs (~~(due to network provider~~  
3 ~~reimbursement schedules or type of network))~~ for a plan. This  
4 subsection does not restrict or enhance the portability of benefits as  
5 provided in RCW 48.43.015.

6 (i) Except for small group health benefit plans that qualify as  
7 insurance coverage combined with a health savings account as defined by  
8 the United States internal revenue service, adjusted community rates  
9 established under this section shall pool the medical experience of all  
10 small groups purchasing coverage, including the small group  
11 participants in the health insurance partnership established in RCW  
12 70.47A.030. However, annual rate adjustments for each small group  
13 health benefit plan may vary by up to plus or minus four percentage  
14 points from the overall adjustment of a carrier's entire small group  
15 pool(~~(, such overall adjustment to be approved by the commissioner,~~  
16 ~~upon a showing by the carrier, certified by a member of the American~~  
17 ~~academy of actuaries that: (i) The variation is a result of deductible~~  
18 ~~leverage, benefit design, or provider network characteristics; and (ii)~~  
19 ~~for a rate renewal period, the projected weighted average of all small~~  
20 ~~group benefit plans will have a revenue neutral effect on the carrier's~~  
21 ~~small group pool. Variations of greater than four percentage points~~  
22 ~~are subject to review by the commissioner, and must be approved or~~  
23 ~~denied within sixty days of submittal.)) if certified by a member of  
24 the American academy of actuaries, that: (i) The variation is a result  
25 of deductible leverage, benefit design, claims cost trend for the plan,  
26 or provider network characteristics; and (ii) for a rate renewal  
27 period, the projected weighted average of all small group benefit plans  
28 will have a revenue neutral effect on the carrier's small group pool.  
29 Variations of greater than eight percentage points are subject to  
30 review by the commissioner, and must be approved or denied within  
31 thirty days of submittal. A variation that is not denied within  
32 (~~sixty~~) thirty days shall be deemed approved. The commissioner must  
33 provide to the carrier a detailed actuarial justification for any  
34 denial (~~(within thirty days))~~ at the time of the denial.~~

35 (j) For health benefit plans purchased through the health insurance  
36 partnership established in chapter 70.47A RCW:

37 (i) Any surcharge established pursuant to RCW 70.47A.030(2)(e)

1 shall be applied only to health benefit plans purchased through the  
2 health insurance partnership; and

3 (ii) Risk adjustment or reinsurance mechanisms may be used by the  
4 health insurance partnership program to redistribute funds to carriers  
5 participating in the health insurance partnership based on differences  
6 in risk attributable to individual choice of health plans or other  
7 factors unique to health insurance partnership participation. Use of  
8 such mechanisms shall be limited to the partnership program and will  
9 not affect small group health plans offered outside the partnership.

10 ~~((+4))~~ (5) Nothing in this section shall restrict the right of  
11 employees to collectively bargain for insurance providing benefits in  
12 excess of those provided herein.

13 ~~((+5))~~ (6)(a) Except as provided in this subsection, requirements  
14 used by an insurer in determining whether to provide coverage to a  
15 small employer shall be applied uniformly among all small employers  
16 applying for coverage or receiving coverage from the carrier.

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

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

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

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

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

31 (e) Minimum participation requirements and employer premium  
32 contribution requirements adopted by the health insurance partnership  
33 board under RCW 70.47A.110 shall apply only to the employers and  
34 employees who purchase health benefit plans through the health  
35 insurance partnership.

36 ~~((+6))~~ (7) An insurer must offer coverage to all eligible  
37 employees of a small employer and their dependents. An insurer may not  
38 offer coverage to only certain individuals or dependents in a small

1 employer group or to only part of the group. An insurer may not modify  
2 a health plan with respect to a small employer or any eligible employee  
3 or dependent, through riders, endorsements or otherwise, to restrict or  
4 exclude coverage or benefits for specific diseases, medical conditions,  
5 or services otherwise covered by the plan.

6 ~~((+7))~~ (8) As used in this section, "health benefit plan," "small  
7 employer," "adjusted community rate," and "wellness activities" mean  
8 the same as defined in RCW 48.43.005.

9 **Sec. 4.** RCW 48.44.023 and 2008 c 143 s 7 are each amended to read  
10 as follows:

11 (1)~~((+a))~~ A health care services contractor offering any health  
12 benefit plan to a small employer, either directly or through an  
13 association or member-governed group formed specifically for the  
14 purpose of purchasing health care, may offer and actively market to the  
15 small employer ~~((a))~~ no more than one health benefit plan featuring a  
16 limited schedule of covered health care services. ~~((Nothing in this  
17 subsection shall preclude a contractor from offering, or a small  
18 employer from purchasing, other health benefit plans that may have more  
19 comprehensive benefits than those included in the product offered under  
20 this subsection. A contractor offering a health benefit plan under  
21 this subsection shall clearly disclose all covered benefits to the  
22 small employer in a brochure filed with the commissioner.~~

23 ~~(b) A health benefit plan offered under this subsection shall  
24 provide coverage for hospital expenses and services rendered by a  
25 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
26 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,  
27 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,  
28 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.~~

29 ~~(+2))~~ (a) The plan offered under this subsection may be offered  
30 with a choice of cost-sharing arrangements, and may, but is not  
31 required to, comply with: RCW 48.44.210, 48.44.212, 48.44.225,  
32 48.44.240 through 48.44.245, 48.44.290 through 48.44.341, 48.44.344,  
33 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through  
34 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this  
35 subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or  
36 48.42.100.

1        (b) In offering the plan under this subsection, the health care  
2 service contractor must offer the small employer the option of  
3 permitting every category of health care provider to provide health  
4 services or care for conditions covered by the plan pursuant to RCW  
5 48.43.045(1).

6        (2) A health care service contractor offering the plan under  
7 subsection (1) of this section must also offer and actively market to  
8 the small employer at least one additional health benefit plan.

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

16        (~~(3)~~) (4) Premium rates for health benefit plans for small  
17 employers as defined in this section shall be subject to the following  
18 provisions:

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

- 21        (i) Geographic area;
- 22        (ii) Family size;
- 23        (iii) Age; and
- 24        (iv) Wellness activities.

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

29        (c) The contractor shall be permitted to develop separate rates for  
30 individuals age sixty-five or older for coverage for which medicare is  
31 the primary payer and coverage for which medicare is not the primary  
32 payer. Both rates shall be subject to the requirements of this  
33 subsection (~~(3)~~) (4).

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



1 (e) A discount for wellness activities shall be permitted to  
2 reflect actuarially justified differences in utilization or cost  
3 attributed to such programs.

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

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

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

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

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

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

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

25 (i) Except for small group health benefit plans that qualify as  
26 insurance coverage combined with a health savings account as defined by  
27 the United States internal revenue service, adjusted community rates  
28 established under this section shall pool the medical experience of all  
29 groups purchasing coverage, including the small group participants in  
30 the health insurance partnership established in RCW 70.47A.030.  
31 However, annual rate adjustments for each small group health benefit  
32 plan may vary by up to plus or minus (~~four~~) eight percentage points  
33 from the overall adjustment of a carrier's entire small group pool(~~(~~  
34 ~~such overall adjustment to be approved by the commissioner, upon a~~  
35 ~~showing by the carrier, certified by a member of the American academy~~  
36 ~~of actuaries that: (i) The variation is a result of deductible~~  
37 ~~leverage, benefit design, or provider network characteristics; and (ii)~~  
38 ~~for a rate renewal period, the projected weighted average of all small~~

1 ~~group benefit plans will have a revenue neutral effect on the carrier's~~  
2 ~~small group pool. Variations of greater than four percentage points~~  
3 ~~are subject to review by the commissioner, and must be approved or~~  
4 ~~denied within sixty days of submittal)) if certified by a member of the~~  
5 ~~American academy of actuaries, that: (i) The variation is a result of~~  
6 ~~deductible leverage, benefit design, claims cost trend for the plan, or~~  
7 ~~provider network characteristics; and (ii) for a rate renewal period,~~  
8 ~~the projected weighted average of all small group benefit plans will~~  
9 ~~have a revenue neutral effect on the carrier's small group pool.~~  
10 ~~Variations of greater than eight percentage points are subject to~~  
11 ~~review by the commissioner, and must be approved or denied within~~  
12 ~~thirty days of submittal.~~ A variation that is not denied within  
13 ~~((sixty)) thirty days shall be deemed approved. The commissioner must~~  
14 provide to the carrier a detailed actuarial justification for any  
15 denial ~~((within thirty days)) at the time of the denial.~~

16 (j) For health benefit plans purchased through the health insurance  
17 partnership established in chapter 70.47A RCW:

18 (i) Any surcharge established pursuant to RCW 70.47A.030(2)(e)  
19 shall be applied only to health benefit plans purchased through the  
20 health insurance partnership; and

21 (ii) Risk adjustment or reinsurance mechanisms may be used by the  
22 health insurance partnership program to redistribute funds to carriers  
23 participating in the health insurance partnership based on differences  
24 in risk attributable to individual choice of health plans or other  
25 factors unique to health insurance partnership participation. Use of  
26 such mechanisms shall be limited to the partnership program and will  
27 not affect small group health plans offered outside the partnership.

28 ~~((+4)) (5) Nothing in this section shall restrict the right of~~  
29 ~~employees to collectively bargain for insurance providing benefits in~~  
30 ~~excess of those provided herein.~~

31 ~~((+5)) (6)(a) Except as provided in this subsection, requirements~~  
32 ~~used by a contractor in determining whether to provide coverage to a~~  
33 ~~small employer shall be applied uniformly among all small employers~~  
34 ~~applying for coverage or receiving coverage from the carrier.~~

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

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

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

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

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

11 (e) Minimum participation requirements and employer premium  
12 contribution requirements adopted by the health insurance partnership  
13 board under RCW 70.47A.110 shall apply only to the employers and  
14 employees who purchase health benefit plans through the health  
15 insurance partnership.

16 ~~((+6+))~~ (7) A contractor must offer coverage to all eligible  
17 employees of a small employer and their dependents. A contractor may  
18 not offer coverage to only certain individuals or dependents in a small  
19 employer group or to only part of the group. A contractor may not  
20 modify a health plan with respect to a small employer or any eligible  
21 employee or dependent, through riders, endorsements or otherwise, to  
22 restrict or exclude coverage or benefits for specific diseases, medical  
23 conditions, or services otherwise covered by the plan.

24 **Sec. 5.** RCW 48.46.066 and 2008 c 143 s 8 are each amended to read  
25 as follows:

26 (1)~~((+a+))~~ A health maintenance organization offering any health  
27 benefit plan to a small employer, either directly or through an  
28 association or member-governed group formed specifically for the  
29 purpose of purchasing health care, may offer and actively market to the  
30 small employer ~~((a))~~ no more than one health benefit plan featuring a  
31 limited schedule of covered health care services. ~~((Nothing in this  
32 subsection shall preclude a health maintenance organization from  
33 offering, or a small employer from purchasing, other health benefit  
34 plans that may have more comprehensive benefits than those included in  
35 the product offered under this subsection. A health maintenance  
36 organization offering a health benefit plan under this subsection shall~~

1 ~~clearly disclose all the covered benefits to the small employer in a~~  
2 ~~brochure filed with the commissioner.~~

3 ~~(b) A health benefit plan offered under this subsection shall~~  
4 ~~provide coverage for hospital expenses and services rendered by a~~  
5 ~~physician licensed under chapter 18.57 or 18.71 RCW but is not subject~~  
6 ~~to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350,~~  
7 ~~48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and~~  
8 ~~48.46.530.~~

9 ~~(2))~~ (a) The plan offered under this subsection may be offered  
10 with a choice of cost-sharing arrangements, and may, but is not  
11 required to, comply with: RCW 48.46.250, 48.46.272 through 48.46.291,  
12 48.46.320, 48.46.350, 48.46.375, 48.46.440 through 48.46.460,  
13 48.46.480, 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.565,  
14 48.46.570, 48.46.575, 48.43.045(1) except as required in (b) of this  
15 subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or  
16 48.42.100.

17 (b) In offering the plan under this subsection, the health  
18 maintenance organization must offer the small employer the option of  
19 permitting every category of health care provider to provide health  
20 services or care for conditions covered by the plan pursuant to RCW  
21 48.43.045(1).

22 (2) A health maintenance organization offering the plan under  
23 subsection (1) of this section must also offer and actively market to  
24 the small employer at least one additional health benefit plan.

25 (3) Nothing in this section shall prohibit a health maintenance  
26 organization from offering, or a purchaser from seeking, health benefit  
27 plans with benefits in excess of the health benefit plan offered under  
28 subsection (1) of this section. All forms, policies, and contracts  
29 shall be submitted for approval to the commissioner, and the rates of  
30 any plan offered under this section shall be reasonable in relation to  
31 the benefits thereto.

32 ~~((3))~~ (4) Premium rates for health benefit plans for small  
33 employers as defined in this section shall be subject to the following  
34 provisions:

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

38 (i) Geographic area;

1 (ii) Family size;

2 (iii) Age; and

3 (iv) Wellness activities.

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

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

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

17 (e) A discount for wellness activities shall be permitted to  
18 reflect actuarially justified differences in utilization or cost  
19 attributed to such programs.

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

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

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

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

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

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

32 (h) For the purposes of this section, a health benefit plan that  
33 contains a restricted network provision shall not be considered similar  
34 coverage to a health benefit plan that does not contain such a  
35 provision, provided that the restrictions of benefits to network  
36 providers result in substantial differences in claims costs. A carrier  
37 may develop its rates based on claims costs (~~(due to network provider~~

1 reimbursement schedules or type of network)) for a plan. This  
2 subsection does not restrict or enhance the portability of benefits as  
3 provided in RCW 48.43.015.

4 (i) Except for small group health benefit plans that qualify as  
5 insurance coverage combined with a health savings account as defined by  
6 the United States internal revenue service, adjusted community rates  
7 established under this section shall pool the medical experience of all  
8 groups purchasing coverage, including the small group participants in  
9 the health insurance partnership established in RCW 70.47A.030.  
10 However, annual rate adjustments for each small group health benefit  
11 plan may vary by up to plus or minus ((four)) eight percentage points  
12 from the overall adjustment of a carrier's entire small group pool(~~(-~~  
13 ~~such overall adjustment to be approved by the commissioner, upon a~~  
14 ~~showing by the carrier, certified by a member of the American academy~~  
15 ~~of actuaries that: (i) The variation is a result of deductible~~  
16 ~~leverage, benefit design, or provider network characteristics; and (ii)~~  
17 ~~for a rate renewal period, the projected weighted average of all small~~  
18 ~~group benefit plans will have a revenue neutral effect on the carrier's~~  
19 ~~small group pool. Variations of greater than four percentage points~~  
20 ~~are subject to review by the commissioner, and must be approved or~~  
21 ~~denied within sixty days of submittal)) if certified by a member of the  
22 American academy of actuaries, that: (i) The variation is a result of  
23 deductible leverage, benefit design, claims cost trend for the plan, or  
24 provider network characteristics; and (ii) for a rate renewal period,  
25 the projected weighted average of all small group benefit plans will  
26 have a revenue neutral effect on the health maintenance organization's  
27 small group pool. Variations of greater than eight percentage points  
28 are subject to review by the commissioner, and must be approved or  
29 denied within thirty days of submittal. A variation that is not denied  
30 within ((sixty)) thirty days shall be deemed approved. The  
31 commissioner must provide to the carrier a detailed actuarial  
32 justification for any denial ((within thirty days)) at the time of the  
33 denial.~~

34 (j) For health benefit plans purchased through the health insurance  
35 partnership established in chapter 70.47A RCW:

36 (i) Any surcharge established pursuant to RCW 70.47A.030(2)(e)  
37 shall be applied only to health benefit plans purchased through the  
38 health insurance partnership; and

1 (ii) Risk adjustment or reinsurance mechanisms may be used by the  
2 health insurance partnership program to redistribute funds to carriers  
3 participating in the health insurance partnership based on differences  
4 in risk attributable to individual choice of health plans or other  
5 factors unique to health insurance partnership participation. Use of  
6 such mechanisms shall be limited to the partnership program and will  
7 not affect small group health plans offered outside the partnership.

8 ~~((+4))~~ (5) Nothing in this section shall restrict the right of  
9 employees to collectively bargain for insurance providing benefits in  
10 excess of those provided herein.

11 ~~((+5))~~ (6)(a) Except as provided in this subsection, requirements  
12 used by a health maintenance organization in determining whether to  
13 provide coverage to a small employer shall be applied uniformly among  
14 all small employers applying for coverage or receiving coverage from  
15 the carrier.

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

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

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

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

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

31 (e) Minimum participation requirements and employer premium  
32 contribution requirements adopted by the health insurance partnership  
33 board under RCW 70.47A.110 shall apply only to the employers and  
34 employees who purchase health benefit plans through the health  
35 insurance partnership.

36 ~~((+6))~~ (7) A health maintenance organization must offer coverage  
37 to all eligible employees of a small employer and their dependents. A  
38 health maintenance organization may not offer coverage to only certain

1 individuals or dependents in a small employer group or to only part of  
2 the group. A health maintenance organization may not modify a health  
3 plan with respect to a small employer or any eligible employee or  
4 dependent, through riders, endorsements or otherwise, to restrict or  
5 exclude coverage or benefits for specific diseases, medical conditions,  
6 or services otherwise covered by the plan.

7 **Sec. 6.** RCW 48.43.041 and 2000 c 79 s 26 are each amended to read  
8 as follows:

9 (1) All individual health benefit plans, other than catastrophic  
10 health plans(~~(, offered or renewed on or after October 1, 2000)~~) and  
11 plans for young adults described in subsection (3) of this section,  
12 shall include benefits described in this section. Nothing in this  
13 section shall be construed to require a carrier to offer an individual  
14 health benefit plan.

15 (a) Maternity services that include, with no enrollee cost-sharing  
16 requirements beyond those generally applicable cost-sharing  
17 requirements: Diagnosis of pregnancy; prenatal care; delivery; care  
18 for complications of pregnancy; physician services; hospital services;  
19 operating or other special procedure rooms; radiology and laboratory  
20 services; appropriate medications; anesthesia; and services required  
21 under RCW 48.43.115; and

22 (b) Prescription drug benefits with at least a two thousand dollar  
23 benefit payable by the carrier annually.

24 (2) If a carrier offers a health benefit plan that is not a  
25 catastrophic health plan to groups, and it chooses to offer a health  
26 benefit plan to individuals, it must offer at least one health benefit  
27 plan to individuals that is not a catastrophic health plan.

28 (3) Carriers may design and offer a separate health plan targeted  
29 at young adults between nineteen and thirty-four years of age. The  
30 plan may include the benefits required under subsections (1) and (2) of  
31 this section but is not required to include these benefits. The health  
32 plan designed for young adults is exempt from the requirements of RCW  
33 48.43.045(1), 48.43.515(5), 48.44.327, 48.20.392, 48.46.277, 48.43.043,  
34 48.20.580, 48.21.241, 48.44.341, and 48.46.291. Carriers who choose to  
35 exclude maternity services from a young adult plan offered under this  
36 section must allow enrollees who become pregnant to transfer to another  
37 health benefit plan with similar cost-sharing provisions that provides



1 coverage for maternity services, once pregnancy is confirmed by a  
2 licensed provider. Carriers shall allow the transfer to occur without  
3 applying a preexisting condition waiting period or other limitation or  
4 penalty including, but not limited to, satisfying a new deductible or  
5 stop-loss requirement.

6 **Sec. 7.** RCW 48.44.022 and 2006 c 100 s 3 are each amended to read  
7 as follows:

8 (1) Except for health benefit plans covered under RCW 48.44.021,  
9 premium rates for health benefit plans for individuals shall be subject  
10 to the following provisions:

11 (a) The health care service contractor 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 care service contractor 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) Except as provided in subsection (2) of this section, the  
29 permitted rates for any age group shall be no more than four hundred  
30 twenty-five percent of the lowest rate for all age groups on January 1,  
31 1996, four hundred percent on January 1, 1997, and three hundred  
32 seventy-five percent on January 1, 2000, and thereafter.

33 (e) A discount for wellness activities shall be permitted to  
34 reflect actuarially justified differences in utilization or cost  
35 attributed to such programs.

36 (f) The rate charged for a health benefit plan offered under this

1 section may not be adjusted more frequently than annually except that  
2 the premium may be changed to reflect:

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

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

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

17 (2) Adjusted community rates established under this section shall  
18 pool the medical experience of all individuals purchasing coverage,  
19 except individuals purchasing coverage under RCW 48.44.021, and shall  
20 not be required to be pooled with the medical experience of health  
21 benefit plans offered to small employers under RCW 48.44.023. Carriers  
22 may treat young adults and products developed specifically for them  
23 consistent with RCW 48.43.041(3) as a single-banded experience pool for  
24 purposes of establishing rates. The rates established for this age  
25 group are not subject to subsection (1)(d) of this section.

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

29 **Sec. 8.** RCW 48.46.064 and 2006 c 100 s 5 are each amended to read  
30 as follows:

31 (1) Except for health benefit plans covered under RCW 48.46.063,  
32 premium rates for health benefit plans for individuals shall be subject  
33 to the following provisions:

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

- 37 (i) Geographic area;

- 1 (ii) Family size;
- 2 (iii) Age;
- 3 (iv) Tenure discounts; and
- 4 (v) Wellness activities.

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

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

14 (d) Except as provided in subsection (2) of this section, the  
15 permitted rates for any age group shall be no more than four hundred  
16 twenty-five percent of the lowest rate for all age groups on January 1,  
17 1996, four hundred percent on January 1, 1997, and three hundred  
18 seventy-five percent on January 1, 2000, and thereafter.

19 (e) A discount for wellness activities shall be permitted to  
20 reflect actuarially justified differences in utilization or cost  
21 attributed to such programs.

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

- 25 (i) Changes to the family composition;
- 26 (ii) Changes to the health benefit plan requested by the  
27 individual; or
- 28 (iii) Changes in government requirements affecting the health  
29 benefit plan.

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

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

1 (2) Adjusted community rates established under this section shall  
2 pool the medical experience of all individuals purchasing coverage,  
3 except individuals purchasing coverage under RCW 48.46.063, and shall  
4 not be required to be pooled with the medical experience of health  
5 benefit plans offered to small employers under RCW 48.46.066. Carriers  
6 may treat young adults and products developed specifically for them  
7 consistent with RCW 48.43.041(3) as a single-banded experience pool for  
8 purposes of establishing rates. The rates established for this age  
9 group are not subject to subsection (1)(d) of this section.

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

13 **Sec. 9.** RCW 48.20.029 and 2006 c 100 s 2 are each amended to read  
14 as follows:

15 (1) Premiums for health benefit plans for individuals who purchase  
16 the plan as a member of a purchasing pool:

17 (a) Consisting of five hundred or more individuals affiliated with  
18 a particular industry;

19 (b) To whom care management services are provided as a benefit of  
20 pool membership; and

21 (c) Which allows contributions from more than one employer to be  
22 used towards the purchase of an individual's health benefit plan;  
23 shall be calculated using the adjusted community rating method that  
24 spreads financial risk across the entire purchasing pool of which the  
25 individual is a member. All such rates shall conform to the following:

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

28 (A) Geographic area;

29 (B) Family size;

30 (C) Age;

31 (D) Tenure discounts; and

32 (E) Wellness activities.

33 (ii) The adjustment for age in (c)(i)(C) 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. Individuals under the age  
36 of twenty shall be treated as those age twenty.

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

5 (iv) Except as provided in subsection (2) of this section, the  
6 permitted rates for any age group shall be no more than four hundred  
7 twenty-five percent of the lowest rate for all age groups on January 1,  
8 1996, four hundred percent on January 1, 1997, and three hundred  
9 seventy-five percent on January 1, 2000, and thereafter.

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

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

16 (A) Changes to the family composition;

17 (B) Changes to the health benefit plan requested by the individual;

18 or

19 (C) Changes in government requirements affecting the health benefit  
20 plan.

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

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

30 (2) Adjusted community rates established under this section shall  
31 not be required to be pooled with the medical experience of health  
32 benefit plans offered to small employers under RCW 48.21.045. Carriers  
33 may treat young adults and products developed specifically for them  
34 consistent with RCW 48.43.041(3) as a single-banded experience pool for  
35 purposes of establishing rates. The rates established for this age  
36 group are not subject to subsection (1)(c)(iv) of this section.

37 (3) As used in this section, "health benefit plan," "adjusted

1 community rates," and "wellness activities" mean the same as defined in  
2 RCW 48.43.005.

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

5 The office of the insurance commissioner shall make available  
6 educational and outreach materials targeted to young adults aged  
7 nineteen to thirty-four, as funding becomes available. Education and  
8 outreach efforts shall focus on educating young consumers on the  
9 importance and value of health insurance, including educational  
10 materials, public service messages, and other outreach activities. The  
11 commissioner is authorized to fund these activities with grants,  
12 donations, in-kind contributions, or other funding that may be  
13 available.

14 NEW SECTION. **Sec. 11.** As used in this chapter:

15 (1) "Commissioner" means the insurance commissioner.

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

20 (3) "Foreign health carrier" means a foreign individual health  
21 carrier or a foreign small employer health carrier.

22 (4) "Foreign individual health carrier" means a carrier licensed to  
23 sell individual health benefits plans in any other state.

24 (5) "Foreign small employer health carrier" means a carrier  
25 licensed to sell small employer health benefits plans in any other  
26 state.

27 (6) "Hazardous financial condition" means that, based on its  
28 present or reasonably anticipated financial condition, a foreign health  
29 carrier is unlikely to be able to meet obligations to policyholders  
30 with respect to known claims or to any other obligations in the normal  
31 course of business.

32 (7) "Health care provider" means an individual or entity which,  
33 acting within the scope of its license or certification, provides  
34 health care services, and includes, but is not limited to, a physician,  
35 dentist, nurse, or other health care professional whose professional  
36 practice is regulated pursuant to Title 18 RCW.

1 (8) "Individual health benefits plan" means a benefits plan for  
2 persons and their dependents which pays or provides for hospital and  
3 medical expense benefits for covered services.

4 (9) "Office" means the office of the insurance commissioner.

5 (10) "Resident" means a person whose primary residence is in  
6 Washington and who is present in Washington for at least six months of  
7 the calendar year.

8 (11) "Small employer health benefits plan" means a group benefits  
9 plan for persons and their dependents which pays or provides for  
10 hospital and medical expense benefits for covered services, offered by  
11 any person, firm, corporation, or partnership actively engaged in a  
12 business that employs at least two but not more than fifty employees.

13 NEW SECTION. **Sec. 12.** (1) Notwithstanding any other law or rule  
14 to the contrary, a foreign individual health carrier may offer and  
15 provide individual health benefits plans to residents in this state, if  
16 that carrier:

17 (a) Offers the same individual health benefits plans in its  
18 domiciliary state and is in compliance with all applicable laws,  
19 regulations, and other requirements of its domiciliary state; and

20 (b) Obtains a certificate of authority to do business as a foreign  
21 health carrier in this state, pursuant to section 13 of this act.

22 (2) Notwithstanding any other law to the contrary, a foreign small  
23 employer health carrier may offer and provide small employer health  
24 benefits plans to employers in this state, if that carrier:

25 (a) Offers the same small employer health benefits plans in its  
26 domiciliary state and is in compliance with all applicable laws,  
27 regulations, and other requirements of its domiciliary state; and

28 (b) Obtains a certificate of authority to do business as a foreign  
29 health carrier in this state, pursuant to section 13 of this act.

30 NEW SECTION. **Sec. 13.** (1) A foreign health carrier may apply for  
31 a certificate of authority to do business as a foreign health carrier  
32 in this state, using a form prescribed by the commissioner. Upon  
33 application, the commissioner shall issue a certificate of authority to  
34 the foreign health carrier unless the commissioner determines that the  
35 carrier:

1 (a) Will not provide health insurance services in compliance with  
2 the provisions of this chapter;

3 (b) Is in a hazardous financial condition, as determined by an  
4 examination by the commissioner conducted in accordance with the  
5 financial analysis handbook of the national association of insurance  
6 commissioners; or

7 (c) Has not adopted procedures to ensure compliance with all  
8 applicable federal and state laws.

9 (2) A certificate of authority issued pursuant to this section  
10 shall be valid for three years from the date of issuance by the  
11 commissioner.

12 (3) The commissioner shall establish by rule:

13 (a) Procedures for a foreign health carrier to renew a certificate  
14 of authority, pursuant to and consistent with the provisions of this  
15 chapter; and

16 (b) A certificate of authority application and renewal fees, the  
17 amount of which shall be no greater than is reasonably necessary to  
18 enable the office to carry out the provisions of this chapter.

19 NEW SECTION. **Sec. 14.** (1) Each individual health benefits plan  
20 provided by a foreign individual health carrier to a resident of this  
21 state, and each application for the plan, shall disclose in plain  
22 language the following:

23 (a) The differences between the individual health benefits plan  
24 issued by the foreign health carrier, and a policy issued in this state  
25 subject to the requirements of Title 48 RCW, using at least fourteen-  
26 point boldface type to describe the differences that relate to:  
27 Underwriting standards, premium rating, preexisting conditions,  
28 renewability, portability, and cancellation; and

29 (b) An explanation of which state's laws govern the issuance of,  
30 and requirements under, the individual health benefits plan offered  
31 under this chapter.

32 (2) Each small employer health benefits plan provided by a foreign  
33 small employer health carrier to an employer in this state, and each  
34 application for the plan, shall disclose in plain language the  
35 following:

36 (a) The differences between the small employer health benefits plan  
37 issued by the foreign health carrier, and a policy issued in this state



1 subject to the requirements of Title 48 RCW, using at least fourteen-  
2 point boldface type to describe the differences that relate to:  
3 Underwriting standards, premium rating, preexisting conditions,  
4 renewability, portability, and cancellation; and

5 (b) An explanation of which state's laws govern the issuance of,  
6 and requirements under, the small employer health benefits plan offered  
7 under this chapter.

8 NEW SECTION. **Sec. 15.** (1) The commissioner may deny, revoke, or  
9 suspend, after notice and opportunity to be heard, a certificate of  
10 authority issued to a foreign health carrier pursuant to this chapter  
11 for a violation of the provisions of this chapter, including any  
12 finding by the commissioner that a foreign health carrier is no longer  
13 in compliance with any of the conditions for issuance of a certificate  
14 of authority set forth in section 13(1) of this act, or the rules  
15 adopted pursuant to this chapter. The commissioner shall provide for  
16 an appropriate and timely right of appeal for the foreign health  
17 carrier whose certificate is denied, revoked, or suspended.

18 (2) The commissioner shall establish grievance and independent  
19 claims review procedures with respect to claims by a health care  
20 carrier or a covered person with which a foreign health carrier shall  
21 comply as a condition of issuing policies in this state.

22 (3)(a) The commissioner shall establish fair marketing standards  
23 for marketing materials used by foreign health carriers to market  
24 individual health benefits plans to residents in this state.

25 (b) The commissioner shall establish fair marketing standards for  
26 marketing materials used by foreign health carriers to market small  
27 employer health benefits plans to small employers in this state.

28 (4) The procedures and standards established under subsections (2)  
29 and (3) of this section shall be applied on a nondiscriminatory basis  
30 so as not to place greater responsibilities on foreign health carriers  
31 than the responsibilities placed on other health carriers doing  
32 business in this state.

33 NEW SECTION. **Sec. 16.** A domestic carrier authorized to do  
34 business in this state may apply to the commissioner for an exemption  
35 from the provisions of this title and any rules promulgated under those  
36 provisions, that would allow the domestic carrier to offer health care

1 plans that are comparable in plan design to health care plans offered  
2 by foreign health carriers under this chapter. Upon a domestic  
3 carrier's application, the commissioner shall make an order exempting  
4 the domestic carrier from those provisions and rules in order to allow  
5 the domestic carrier to offer a health care plan or plans that are  
6 comparable in design to health care plans offered by foreign health  
7 carriers under this chapter. Any health care plan offer by a domestic  
8 carrier under an exemption under this section shall be subject to the  
9 requirements that apply to health care plans offered by foreign health  
10 carriers under this chapter.

11 NEW SECTION. **Sec. 17.** The office shall adopt rules to effectuate  
12 the purposes of this chapter, provided, however, that the rules shall  
13 not:

14 (1) Directly or indirectly require a foreign health carrier to,  
15 directly or indirectly, modify coverage or benefit requirements, or  
16 restrict underwriting requirements or premium ratings, in any way that  
17 conflicts with the carrier's domiciliary state's laws or rules;

18 (2) Provide for requirements that are more stringent than those  
19 applicable to carriers that are licensed by the commissioner to provide  
20 health benefits plans in this state; or

21 (3) Require any individual health benefits plan or small employer  
22 health benefits plan issued by the foreign health carrier to be  
23 countersigned by an insurance agent or broker residing in this state.

24 NEW SECTION. **Sec. 18.** Sections 11 through 17 of this act  
25 constitute a new chapter in Title 48 RCW.

26 NEW SECTION. **Sec. 19.** If any provision of this act or its  
27 application to any person or circumstance is held invalid, the  
28 remainder of the act or the application of the provision to other  
29 persons or circumstances is not affected."

30 Correct the title.

--- END ---