CERTIFICATION OF ENROLLMENT

SUBSTITUTE SENATE BILL 6019

61st Legislature
2009 Regular Session

Passed by the Senate March 9, 2009
YEAS 45 NAYS 0

President of the Senate

Passed by the House April 8, 2009
YEAS 98 NAYS 0

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SUBSTITUTE SENATE BILL 6019** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

Secretary of State
State of Washington

SUBSTITUTE SENATE BILL 6019

Passed Legislature - 2009 Regular Session

State of Washington 61st Legislature 2009 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Parlette, Kilmer, Jarrett, Tom, Holmquist, Pflug, Shin, and Schoesler)

READ FIRST TIME 02/25/09.

1 AN ACT Relating to employee wellness programs; and amending RCW
2 48.21.045, 48.44.023, and 48.46.066.

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

4 **Sec. 1.** RCW 48.21.045 and 2008 c 143 s 6 are each amended to read
5 as follows:
6 (1)(a) An insurer offering any health benefit plan to a small
7 employer, either directly or through an association or member-governed
8 group formed specifically for the purpose of purchasing health care,
9 may offer and actively market to the small employer a health benefit
10 plan featuring a limited schedule of covered health care services.
11 Nothing in this subsection shall preclude an insurer from offering, or
12 a small employer from purchasing, other health benefit plans that may
13 have more comprehensive benefits than those included in the product
14 offered under this subsection. An insurer offering a health benefit
15 plan under this subsection shall clearly disclose all covered benefits
16 to the small employer in a brochure filed with the commissioner.
17 (b) A health benefit plan offered under this subsection shall
18 provide coverage for hospital expenses and services rendered by a
19 physician licensed under chapter 18.57 or 18.71 RCW but is not subject

1 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,
2 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,
3 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250,
4 48.21.300, 48.21.310, or 48.21.320.

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

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

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

16 (i) Geographic area;

17 (ii) Family size;

18 (iii) Age; and

19 (iv) Wellness activities.

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

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

29 (d) The permitted rates for any age group shall be no more than
30 four hundred twenty-five percent of the lowest rate for all age groups
31 on January 1, 1996, four hundred percent on January 1, 1997, and three
32 hundred 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. <u>Up to a twenty percent variance may be
36 allowed for small employers that develop and implement a wellness
37 program or activities that directly improve employee wellness.
38 Employers shall document program activities with the carrier and may,</u>

after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(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. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. 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, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be

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

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

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

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

25 (4) Nothing in this section shall restrict the right of employees
26 to collectively bargain for insurance providing benefits in excess of
27 those provided herein.

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

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

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

36 (ii) Seventy-five percent of eligible employees working for groups
37 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.

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

(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," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 2. RCW 48.44.023 and 2008 c 143 s 7 are each amended to read as follows:

(1)(a) A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit 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 comprehensive benefits than those included in the product offered under this subsection. A contractor offering a health benefit plan under this

subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with 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, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

(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 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

1 attributed to such programs. Up to a twenty percent variance may be
2 allowed for small employers that develop and implement a wellness
3 program or activities that directly improve employee wellness.
4 Employers shall document program activities with the carrier and may,
5 after three years of implementation, request a reduction in premiums
6 based on improved employee health and wellness. While carriers may
7 review the employer's claim history when making a determination
8 regarding whether the employer's wellness program has improved employee
9 health, the carrier may not use maternity or prevention services claims
10 to deny the employer's request. Carriers may consider issues such as
11 improved productivity or a reduction in absenteeism due to illness if
12 submitted by the employer for consideration. Interested employers may
13 also work with the carrier to develop a wellness program and a means to
14 track improved employee health.
15 (f) The rate charged for a health benefit plan offered under this
16 section may not be adjusted more frequently than annually except that
17 the premium may be changed to reflect:
18 (i) Changes to the enrollment of the small employer;
19 (ii) Changes to the family composition of the employee;
20 (iii) Changes to the health benefit plan requested by the small
21 employer; or
22 (iv) Changes in government requirements affecting the health
23 benefit plan.
24 (g) Rating factors shall produce premiums for identical groups that
25 differ only by the amounts attributable to plan design, with the
26 exception of discounts for health improvement programs.
27 (h) For the purposes of this section, a health benefit plan that
28 contains a restricted network provision shall not be considered similar
29 coverage to a health benefit plan that does not contain such a
30 provision, provided that the restrictions of benefits to network
31 providers result in substantial differences in claims costs. A carrier
32 may develop its rates based on claims costs due to network provider
33 reimbursement schedules or type of network. This subsection does not
34 restrict or enhance the portability of benefits as provided in RCW
35 48.43.015.
36 (i) Adjusted community rates established under this section shall
37 pool the medical experience of all groups purchasing coverage,
38 including the small group participants in the health insurance

1 partnership established in RCW 70.47A.030. However, annual rate
2 adjustments for each small group health benefit plan may vary by up to
3 plus or minus four percentage points from the overall adjustment of a
4 carrier's entire small group pool, such overall adjustment to be
5 approved by the commissioner, upon a showing by the carrier, certified
6 by a member of the American academy of actuaries that: (i) The
7 variation is a result of deductible leverage, benefit design, or
8 provider network characteristics; and (ii) for a rate renewal period,
9 the projected weighted average of all small group benefit plans will
10 have a revenue neutral effect on the carrier's small group pool.
11 Variations of greater than four percentage points are subject to review
12 by the commissioner, and must be approved or denied within sixty days
13 of submittal. A variation that is not denied within sixty days shall
14 be deemed approved. The commissioner must provide to the carrier a
15 detailed actuarial justification for any denial within thirty days of
16 the denial.
17 (j) For health benefit plans purchased through the health insurance
18 partnership established in chapter 70.47A RCW:
19 (i) Any surcharge established pursuant to RCW 70.47A.030(2)(e)
20 shall be applied only to health benefit plans purchased through the
21 health insurance partnership; and
22 (ii) Risk adjustment or reinsurance mechanisms may be used by the
23 health insurance partnership program to redistribute funds to carriers
24 participating in the health insurance partnership based on differences
25 in risk attributable to individual choice of health plans or other
26 factors unique to health insurance partnership participation. Use of
27 such mechanisms shall be limited to the partnership program and will
28 not affect small group health plans offered outside the partnership.
29 (4) Nothing in this section shall restrict the right of employees
30 to collectively bargain for insurance providing benefits in excess of
31 those provided herein.
32 (5)(a) Except as provided in this subsection, requirements used by
33 a contractor in determining whether to provide coverage to a small
34 employer shall be applied uniformly among all small employers applying
35 for coverage or receiving coverage from the carrier.
36 (b) A contractor shall not require a minimum participation level
37 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.

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

(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.

Sec. 3. RCW 48.46.066 and 2008 c 143 s 8 are each amended to read as follows:

(1)(a) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit 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 comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health

1 benefit plan under this subsection shall clearly disclose all the
2 covered benefits to the small employer in a brochure filed with the
3 commissioner.
4 (b) A health benefit plan offered under this subsection shall
5 provide coverage for hospital expenses and services rendered by a
6 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
7 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350,
8 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and
9 48.46.530.
10 (2) Nothing in this section shall prohibit a health maintenance
11 organization from offering, or a purchaser from seeking, health benefit
12 plans with benefits in excess of the health benefit plan offered under
13 subsection (1) of this section. All forms, policies, and contracts
14 shall be submitted for approval to the commissioner, and the rates of
15 any plan offered under this section shall be reasonable in relation to
16 the benefits thereto.
17 (3) Premium rates for health benefit plans for small employers as
18 defined in this section shall be subject to the following provisions:
19 (a) The health maintenance organization shall develop its rates
20 based on an adjusted community rate and may only vary the adjusted
21 community rate for:
22 (i) Geographic area;
23 (ii) Family size;
24 (iii) Age; and
25 (iv) Wellness activities.
26 (b) The adjustment for age in (a)(iii) of this subsection may not
27 use age brackets smaller than five-year increments, which shall begin
28 with age twenty and end with age sixty-five. Employees under the age
29 of twenty shall be treated as those age twenty.
30 (c) The health maintenance organization shall be permitted to
31 develop separate rates for individuals age sixty-five or older for
32 coverage for which medicare is the primary payer and coverage for which
33 medicare is not the primary payer. Both rates shall be subject to the
34 requirements of this subsection (3).
35 (d) The permitted rates for any age group shall be no more than
36 four hundred twenty-five percent of the lowest rate for all age groups
37 on January 1, 1996, four hundred percent on January 1, 1997, and three
38 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. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may, after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers may consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(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. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. 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, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

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

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

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

(4) 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.

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

(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.

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