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**SENATE BILL 5805**

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**State of Washington**

**66th Legislature**

**2019 Regular Session**

**By** Senators Cleveland, Wellman, Randall, Billig, Nguyen, Pedersen, Saldaña, Carlyle, Kuderer, Wilson, C., Conway, Darneille, Hasegawa, Takko, Keiser, Frockt, Hunt, Mullet, Rolfes, McCoy, Salomon, Van De Wege, Das, Lias, Hobbs, Palumbo, and Dhingra

1 AN ACT Relating to making state law consistent with selected  
2 federal consumer protections in the patient protection and affordable  
3 care act; amending RCW 48.43.005, 48.20.028, 48.21.045, 48.44.022,  
4 48.44.023, 48.46.064, 48.46.066, 48.43.012, 48.21.270, 48.44.380,  
5 48.46.460, 48.43.715, and 48.43.0122; adding new sections to chapter  
6 48.43 RCW; repealing RCW 48.43.015, 48.43.017, 48.43.018, 48.43.025,  
7 48.20.025, 48.44.017, and 48.46.062; and prescribing penalties.

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

9 **PART I**

10 **DEFINITIONS**

11 **Sec. 1.** RCW 48.43.005 and 2016 c 65 s 2 are each amended to read  
12 as follows:

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

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

1 (2) "Adverse benefit determination" means a denial, reduction, or  
2 termination of, or a failure to provide or make payment, in whole or  
3 in part, for a benefit, including a denial, reduction, termination,  
4 or failure to provide or make payment that is based on a  
5 determination of an enrollee's or applicant's eligibility to  
6 participate in a plan, and including, with respect to group health  
7 plans, a denial, reduction, or termination of, or a failure to  
8 provide or make payment, in whole or in part, for a benefit resulting  
9 from the application of any utilization review, as well as a failure  
10 to cover an item or service for which benefits are otherwise provided  
11 because it is determined to be experimental or investigational or not  
12 medically necessary or appropriate.

13 (3) "Applicant" means a person who applies for enrollment in an  
14 individual health plan as the subscriber or an enrollee, or the  
15 dependent or spouse of a subscriber or enrollee.

16 (4) "Basic health plan" means the plan described under chapter  
17 70.47 RCW, as revised from time to time.

18 (5) "Basic health plan model plan" means a health plan as  
19 required in RCW 70.47.060(2)(e).

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

24 (7) "Board" means the governing board of the Washington health  
25 benefit exchange established in chapter 43.71 RCW.

26 (8)(a) For grandfathered health benefit plans issued before  
27 January 1, 2014, and renewed thereafter, "catastrophic health plan"  
28 means:

29 (i) In the case of a contract, agreement, or policy covering a  
30 single enrollee, a health benefit plan requiring a calendar year  
31 deductible of, at a minimum, one thousand seven hundred fifty dollars  
32 and an annual out-of-pocket expense required to be paid under the  
33 plan (other than for premiums) for covered benefits of at least three  
34 thousand five hundred dollars, both amounts to be adjusted annually  
35 by the insurance commissioner; and

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

1 thousand dollars, both amounts to be adjusted annually by the  
2 insurance commissioner.

3 (b) In July 2008, and in each July thereafter, the insurance  
4 commissioner shall adjust the minimum deductible and out-of-pocket  
5 expense required for a plan to qualify as a catastrophic plan to  
6 reflect the percentage change in the consumer price index for medical  
7 care for a preceding twelve months, as determined by the United  
8 States department of labor. For a plan year beginning in 2014, the  
9 out-of-pocket limits must be adjusted as specified in section  
10 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount  
11 shall apply on the following January 1st.

12 (c) For health benefit plans issued on or after January 1, 2014,  
13 "catastrophic health plan" means:

14 (i) A health benefit plan that meets the definition of  
15 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of  
16 2010, as amended; or

17 (ii) A health benefit plan offered outside the exchange  
18 marketplace that requires a calendar year deductible or out-of-pocket  
19 expenses under the plan, other than for premiums, for covered  
20 benefits, that meets or exceeds the commissioner's annual adjustment  
21 under (b) of this subsection.

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

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

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

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

37 (13) "Emergency medical condition" means a medical condition  
38 manifesting itself by acute symptoms of sufficient severity,  
39 including severe pain, such that a prudent layperson, who possesses  
40 an average knowledge of health and medicine, could reasonably expect

1 the absence of immediate medical attention to result in a condition  
2 (a) placing the health of the individual, or with respect to a  
3 pregnant woman, the health of the woman or her unborn child, in  
4 serious jeopardy, (b) serious impairment to bodily functions, or (c)  
5 serious dysfunction of any bodily organ or part.

6 (14) "Emergency services" means a medical screening examination,  
7 as required under section 1867 of the social security act (42 U.S.C.  
8 1395dd), that is within the capability of the emergency department of  
9 a hospital, including ancillary services routinely available to the  
10 emergency department to evaluate that emergency medical condition,  
11 and further medical examination and treatment, to the extent they are  
12 within the capabilities of the staff and facilities available at the  
13 hospital, as are required under section 1867 of the social security  
14 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with  
15 respect to an emergency medical condition, has the meaning given in  
16 section 1867(e)(3) of the social security act (42 U.S.C.  
17 1395dd(e)(3)).

18 (15) "Employee" has the same meaning given to the term, as of  
19 January 1, 2008, under section 3(6) of the federal employee  
20 retirement income security act of 1974.

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

25 (17) "Exchange" means the Washington health benefit exchange  
26 established under chapter 43.71 RCW.

27 (18) "Final external review decision" means a determination by an  
28 independent review organization at the conclusion of an external  
29 review.

30 (19) "Final internal adverse benefit determination" means an  
31 adverse benefit determination that has been upheld by a health plan  
32 or carrier at the completion of the internal appeals process, or an  
33 adverse benefit determination with respect to which the internal  
34 appeals process has been exhausted under the exhaustion rules  
35 described in RCW 48.43.530 and 48.43.535.

36 (20) "Grandfathered health plan" means a group health plan or an  
37 individual health plan that under section 1251 of the patient  
38 protection and affordable care act, P.L. 111-148 (2010) and as  
39 amended by the health care and education reconciliation act, P.L.

1 111-152 (2010) is not subject to subtitles A or C of the act as  
2 amended.

3 (21) "Grievance" means a written complaint submitted by or on  
4 behalf of a covered person regarding service delivery issues other  
5 than denial of payment for medical services or nonprovision of  
6 medical services, including dissatisfaction with medical care,  
7 waiting time for medical services, provider or staff attitude or  
8 demeanor, or dissatisfaction with service provided by the health  
9 carrier.

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

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

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

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

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

32 (25) "Health carrier" or "carrier" means a disability insurer  
33 regulated under chapter 48.20 or 48.21 RCW, a health care service  
34 contractor as defined in RCW 48.44.010, or a health maintenance  
35 organization as defined in RCW 48.46.020, and includes "issuers" as  
36 that term is used in the patient protection and affordable care act  
37 (P.L. 111-148).

38 (26) "Health plan" or "health benefit plan" means any policy,  
39 contract, or agreement offered by a health carrier to provide,

1 arrange, reimburse, or pay for health care services except the  
2 following:

3 (a) Long-term care insurance governed by chapter 48.84 or 48.83  
4 RCW;

5 (b) Medicare supplemental health insurance governed by chapter  
6 48.66 RCW;

7 (c) Coverage supplemental to the coverage provided under chapter  
8 55, Title 10, United States Code;

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

11 (e) Disability income;

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

15 (g) Workers' compensation coverage;

16 (h) Accident only coverage;

17 (i) Specified disease or illness-triggered fixed payment  
18 insurance, hospital confinement fixed payment insurance, or other  
19 fixed payment insurance offered as an independent, noncoordinated  
20 benefit;

21 (j) Employer-sponsored self-funded health plans;

22 (k) Dental only and vision only coverage;

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

30 (m) Civilian health and medical program for the veterans affairs  
31 administration (CHAMPVA).

32 (27) "Individual market" means the market for health insurance  
33 coverage offered to individuals other than in connection with a group  
34 health plan.

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

38 (29) "Open enrollment" means a period of time as defined in rule  
39 to be held at the same time each year, during which applicants may  
40 enroll in a carrier's individual health benefit plan without being

1 subject to health screening or otherwise required to provide evidence  
2 of insurability as a condition for enrollment.

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

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

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

19 (33) "Small employer" or "small group" means any person, firm,  
20 corporation, partnership, association, political subdivision, sole  
21 proprietor, or self-employed individual that is actively engaged in  
22 business that employed an average of at least one but no more than  
23 fifty employees, during the previous calendar year and employed at  
24 least one employee on the first day of the plan year, is not formed  
25 primarily for purposes of buying health insurance, and in which a  
26 bona fide employer-employee relationship exists. In determining the  
27 number of employees, companies that are affiliated companies, or that  
28 are eligible to file a combined tax return for purposes of taxation  
29 by this state, shall be considered an employer. Subsequent to the  
30 issuance of a health plan to a small employer and for the purpose of  
31 determining eligibility, the size of a small employer shall be  
32 determined annually. Except as otherwise specifically provided, a  
33 small employer shall continue to be considered a small employer until  
34 the plan anniversary following the date the small employer no longer  
35 meets the requirements of this definition. A self-employed individual  
36 or sole proprietor who is covered as a group of one must also: (a)  
37 Have been employed by the same small employer or small group for at  
38 least twelve months prior to application for small group coverage,  
39 and (b) verify that he or she derived at least seventy-five percent  
40 of his or her income from a trade or business through which the

1 individual or sole proprietor has attempted to earn taxable income  
2 and for which he or she has filed the appropriate internal revenue  
3 service form 1040, schedule C or F, for the previous taxable year,  
4 except a self-employed individual or sole proprietor in an  
5 agricultural trade or business, must have derived at least fifty-one  
6 percent of his or her income from the trade or business through which  
7 the individual or sole proprietor has attempted to earn taxable  
8 income and for which he or she has filed the appropriate internal  
9 revenue service form 1040, for the previous taxable year.

10 (34) "Special enrollment" means a defined period of time of not  
11 less than thirty-one days, triggered by a specific qualifying event  
12 experienced by the applicant, during which applicants may enroll in  
13 the carrier's individual health benefit plan without being subject to  
14 health screening or otherwise required to provide evidence of  
15 insurability as a condition for enrollment.

16 (35) "Standard health questionnaire" means the standard health  
17 questionnaire designated under chapter 48.41 RCW.

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

23 (37) "Wellness activity" means an explicit program of an activity  
24 consistent with department of health guidelines, such as, smoking  
25 cessation, injury and accident prevention, reduction of alcohol  
26 misuse, appropriate weight reduction, exercise, automobile and  
27 motorcycle safety, blood cholesterol reduction, and nutrition  
28 education for the purpose of improving enrollee health status and  
29 reducing health service costs.

30 (38) "Essential health benefit categories" means:

31 (a) Ambulatory patient services;

32 (b) Emergency services;

33 (c) Hospitalization;

34 (d) Maternity and newborn care;

35 (e) Mental health and substance use disorder services, including  
36 behavioral health treatment;

37 (f) Prescription drugs;

38 (g) Rehabilitative and habilitative services;

39 (h) Laboratory services;



- 1 (i) Preventive and wellness services and chronic disease  
2 management; and  
3 (j) Pediatric services, including oral and vision care.

4 **PART II**  
5 **MODIFIED COMMUNITY RATING**

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

8 (1) The premium rate charged by a health carrier for  
9 nongrandfathered health plans offered in the individual or small  
10 group market may vary with respect to the particular plan involved  
11 only by:

- 12 (a) Whether the plan covers an individual or family;  
13 (b) Rating area established under subsection (2) of this section;  
14 (c) Age, except the rate may not vary by more than three to one  
15 for adults; and  
16 (d) Tobacco use, except the rate may not vary by more than one  
17 and one-half to one.

18 (2) The commissioner shall establish by rule:

- 19 (a) Rating areas for purposes of subsection (1)(b) of this  
20 section; and  
21 (b) Permissible age bands for purposes of subsection (1)(c) of  
22 this section.

23 (3) With respect to family coverage, the rating variations  
24 permitted under subsection (1)(d) of this section must be applied  
25 based on the portion of the premium that is attributable to each  
26 family member covered under the plan.

27 (4) Unless preempted by federal law, the commissioner shall adopt  
28 any rules necessary to implement this section, consistent with  
29 federal rules and guidance in effect on January 1, 2017, implementing  
30 the patient protection and affordable care act.

31 **Sec. 3.** RCW 48.20.028 and 2006 c 100 s 1 are each amended to  
32 read as follows:

33 (1) Premiums for health benefit plans for individuals shall be  
34 calculated using the adjusted community rating method that spreads  
35 financial risk across the carrier's entire individual product  
36 population, except the individual product population covered under  
37 RCW 48.20.029. All such rates shall conform to the following:

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;
- 6 (iv) Tenure discounts; and
- 7 (v) Wellness activities.

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

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

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

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

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

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

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

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

3 (2) Adjusted community rates established under this section shall  
4 pool the medical experience of all individuals purchasing coverage,  
5 except individuals purchasing coverage under RCW 48.20.029, and shall  
6 not be required to be pooled with the medical experience of health  
7 benefit plans offered to small employers under RCW 48.21.045.

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

11 (4) This section shall not apply to premiums for health benefit  
12 plans covered under RCW 48.20.029.

13 (5) This section applies only to grandfathered health plans as  
14 defined in RCW 48.43.005.

15 **Sec. 4.** RCW 48.21.045 and 2010 c 292 s 7 are each amended to  
16 read as follows:

17 (1)(a) An insurer offering any health benefit plan to a small  
18 employer, either directly or through an association or member-  
19 governed group formed specifically for the purpose of purchasing  
20 health care, may offer and actively market to the small employer a  
21 health benefit plan featuring a limited schedule of covered health  
22 care services. Nothing in this subsection shall preclude an insurer  
23 from offering, or a small employer from purchasing, other health  
24 benefit plans that may have more comprehensive benefits than those  
25 included in the product offered under this subsection. An insurer  
26 offering a health benefit plan under this subsection shall clearly  
27 disclose all covered benefits to the small employer in a brochure  
28 filed with the commissioner.

29 (b) A health benefit plan offered under this subsection shall  
30 provide coverage for hospital expenses and services rendered by a  
31 physician licensed under chapter 18.57 or 18.71 RCW but is not  
32 subject to the requirements of RCW 48.21.130, 48.21.140, 48.21.141,  
33 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197,  
34 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244,  
35 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

36 (2) Nothing in this section shall prohibit an insurer from  
37 offering, or a purchaser from seeking, health benefit plans with  
38 benefits in excess of the health benefit plan offered under  
39 subsection (1) of this section. All forms, policies, and contracts

1 shall be submitted for approval to the commissioner, and the rates of  
2 any plan offered under this section shall be reasonable in relation  
3 to the benefits thereto.

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

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

- 8 (i) Geographic area;
- 9 (ii) Family size;
- 10 (iii) Age; and
- 11 (iv) Wellness activities.

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

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

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

26 (e) A discount for wellness activities shall be permitted to  
27 reflect actuarially justified differences in utilization or cost  
28 attributed to such programs. Up to a twenty percent variance may be  
29 allowed for small employers that develop and implement a wellness  
30 program or activities that directly improve employee wellness.  
31 Employers shall document program activities with the carrier and may,  
32 after three years of implementation, request a reduction in premiums  
33 based on improved employee health and wellness. While carriers may  
34 review the employer's claim history when making a determination  
35 regarding whether the employer's wellness program has improved  
36 employee health, the carrier may not use maternity or prevention  
37 services claims to deny the employer's request. Carriers may consider  
38 issues such as improved productivity or a reduction in absenteeism  
39 due to illness if submitted by the employer for consideration.

1 Interested employers may also work with the carrier to develop a  
2 wellness program and a means to track improved employee health.

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

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

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

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

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

12 (g) On the census date, as defined in RCW 48.21.047, rating  
13 factors shall produce premiums for identical groups that differ only  
14 by the amounts attributable to plan design, and differences in census  
15 date between new and renewal groups, with the exception of discounts  
16 for health improvement programs.

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

26 (i) Adjusted community rates established under this section shall  
27 pool the medical experience of all small groups purchasing coverage,  
28 including the small group participants in the health insurance  
29 partnership established in RCW 70.47A.030. However, annual rate  
30 adjustments for each small group health benefit plan may vary by up  
31 to plus or minus four percentage points from the overall adjustment  
32 of a carrier's entire small group pool, such overall adjustment to be  
33 approved by the commissioner, upon a showing by the carrier,  
34 certified by a member of the American academy of actuaries that: (i)  
35 The variation is a result of deductible leverage, benefit design, or  
36 provider network characteristics; and (ii) for a rate renewal period,  
37 the projected weighted average of all small group benefit plans will  
38 have a revenue neutral effect on the carrier's small group pool.  
39 Variations of greater than four percentage points are subject to  
40 review by the commissioner, and must be approved or denied within

1 sixty days of submittal. A variation that is not denied within sixty  
2 days shall be deemed approved. The commissioner must provide to the  
3 carrier a detailed actuarial justification for any denial within  
4 thirty days of the denial.

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

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

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

18 (k) If the rate developed under this section varies the adjusted  
19 community rate for the factors listed in (a) of this subsection, the  
20 date for determining those factors must be no more than ninety days  
21 prior to the effective date of the health benefit plan.

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

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

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

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

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

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

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

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

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

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

21 (8) This section applies only to grandfathered health plans as  
22 defined in RCW 48.43.005.

23 **Sec. 5.** RCW 48.44.022 and 2006 c 100 s 3 are each amended to  
24 read as follows:

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

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

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

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

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

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

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

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

17 (i) Changes to the family composition;

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

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

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

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

31 (2) Adjusted community rates established under this section shall  
32 pool the medical experience of all individuals purchasing coverage,  
33 except individuals purchasing coverage under RCW 48.44.021, and shall  
34 not be required to be pooled with the medical experience of health  
35 benefit plans offered to small employers under RCW 48.44.023.

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

39 (4) This section applies only to grandfathered health plans as  
40 defined in RCW 48.43.005.



1       **Sec. 6.** RCW 48.44.023 and 2010 c 292 s 4 are each amended to  
2 read as follows:

3       (1)(a) A health care services contractor offering any health  
4 benefit plan to a small employer, either directly or through an  
5 association or member-governed group formed specifically for the  
6 purpose of purchasing health care, may offer and actively market to  
7 the small employer a health benefit plan featuring a limited schedule  
8 of covered health care services. Nothing in this subsection shall  
9 preclude a contractor from offering, or a small employer from  
10 purchasing, other health benefit plans that may have more  
11 comprehensive benefits than those included in the product offered  
12 under this subsection. A contractor offering a health benefit plan  
13 under this subsection shall clearly disclose all covered benefits to  
14 the small employer in a brochure filed with the commissioner.

15       (b) A health benefit plan offered under this subsection shall  
16 provide coverage for hospital expenses and services rendered by a  
17 physician licensed under chapter 18.57 or 18.71 RCW but is not  
18 subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245,  
19 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330,  
20 48.44.335, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and  
21 48.44.460.

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

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

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

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

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

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

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

11 (e) A discount for wellness activities shall be permitted to  
12 reflect actuarially justified differences in utilization or cost  
13 attributed to such programs. Up to a twenty percent variance may be  
14 allowed for small employers that develop and implement a wellness  
15 program or activities that directly improve employee wellness.  
16 Employers shall document program activities with the carrier and may,  
17 after three years of implementation, request a reduction in premiums  
18 based on improved employee health and wellness. While carriers may  
19 review the employer's claim history when making a determination  
20 regarding whether the employer's wellness program has improved  
21 employee health, the carrier may not use maternity or prevention  
22 services claims to deny the employer's request. Carriers may consider  
23 issues such as improved productivity or a reduction in absenteeism  
24 due to illness if submitted by the employer for consideration.  
25 Interested employers may also work with the carrier to develop a  
26 wellness program and a means to track improved employee health.

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

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

36 (g) On the census date, as defined in RCW 48.44.010, rating  
37 factors shall produce premiums for identical groups that differ only  
38 by the amounts attributable to plan design, and differences in census  
39 date between new and renewal groups, with the exception of discounts  
40 for health improvement programs.

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

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

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

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

34 (ii) Risk adjustment or reinsurance mechanisms may be used by the  
35 health insurance partnership program to redistribute funds to  
36 carriers participating in the health insurance partnership based on  
37 differences in risk attributable to individual choice of health plans  
38 or other factors unique to health insurance partnership  
39 participation. Use of such mechanisms shall be limited to the

1 partnership program and will not affect small group health plans  
2 offered outside the partnership.

3 (k) If the rate developed under this section varies the adjusted  
4 community rate for the factors listed in (a) of this subsection, the  
5 date for determining those factors must be no more than ninety days  
6 prior to the effective date of the health benefit plan.

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

10 (5)(a) Except as provided in this subsection and subsection  
11 (3)(g) of this section, requirements used by a contractor in  
12 determining whether to provide coverage to a small employer shall be  
13 applied uniformly among all small employers applying for coverage or  
14 receiving coverage from the carrier.

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

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

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

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

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

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

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

1 restrict or exclude coverage or benefits for specific diseases,  
2 medical conditions, or services otherwise covered by the plan.

3 (7) This section applies only to grandfathered health plans as  
4 defined in RCW 48.43.005.

5 **Sec. 7.** RCW 48.46.064 and 2006 c 100 s 5 are each amended to  
6 read as follows:

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

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

- 13 (i) Geographic area;
- 14 (ii) Family size;
- 15 (iii) Age;
- 16 (iv) Tenure discounts; and
- 17 (v) Wellness activities.

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

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

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

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

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

- 38 (i) Changes to the family composition;

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

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

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

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

14 (2) Adjusted community rates established under this section shall  
15 pool the medical experience of all individuals purchasing coverage,  
16 except individuals purchasing coverage under RCW 48.46.063, and shall  
17 not be required to be pooled with the medical experience of health  
18 benefit plans offered to small employers under RCW 48.46.066.

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

22 (4) This section applies only to grandfathered health plans as  
23 defined in RCW 48.43.005.

24 **Sec. 8.** RCW 48.46.066 and 2010 c 292 s 6 are each amended to  
25 read 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  
30 the small employer a health benefit plan featuring a limited schedule  
31 of covered health care services. Nothing in this subsection shall  
32 preclude a health maintenance organization from offering, or a small  
33 employer from purchasing, other health benefit plans that may have  
34 more comprehensive benefits than those included in the product  
35 offered under this subsection. A health maintenance organization  
36 offering a health benefit plan under this subsection shall clearly  
37 disclose all the covered benefits to the small employer in a brochure  
38 filed with the commissioner.

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

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

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

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

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

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

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

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

37 (e) A discount for wellness activities shall be permitted to  
38 reflect actuarially justified differences in utilization or cost  
39 attributed to such programs. Up to a twenty percent variance may be  
40 allowed for small employers that develop and implement a wellness

1 program or activities that directly improve employee wellness.  
2 Employers shall document program activities with the carrier and may,  
3 after three years of implementation, request a reduction in premiums  
4 based on improved employee health and wellness. While carriers may  
5 review the employer's claim history when making a determination  
6 regarding whether the employer's wellness program has improved  
7 employee health, the carrier may not use maternity or prevention  
8 services claims to deny the employer's request. Carriers may consider  
9 issues such as improved productivity or a reduction in absenteeism  
10 due to illness if submitted by the employer for consideration.  
11 Interested employers may also work with the carrier to develop a  
12 wellness program and a means to track improved employee health.

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

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

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

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

22 (g) On the census date, as defined in RCW 48.46.020, rating  
23 factors shall produce premiums for identical groups that differ only  
24 by the amounts attributable to plan design, and differences in census  
25 date between new and renewal groups, with the exception of discounts  
26 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  
29 similar coverage to a health benefit plan that does not contain such  
30 a provision, provided that the restrictions of benefits to network  
31 providers result in substantial differences in claims costs. A  
32 carrier may develop its rates based on claims costs due to network  
33 provider reimbursement schedules or type of network. (~~This~~  
34 ~~subsection does not restrict or enhance the portability of benefits~~  
35 ~~as provided in RCW 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  
39 partnership established in RCW 70.47A.030. However, annual rate  
40 adjustments for each small group health benefit plan may vary by up



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

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

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

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

28 (k) If the rate developed under this section varies the adjusted  
29 community rate for the factors listed in (a) of this subsection, the  
30 date for determining those factors must be no more than ninety days  
31 prior to the effective date of the health benefit plan.

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

35 (5)(a) Except as provided in this subsection and subsection  
36 (3)(g) of this section, requirements used by a health maintenance  
37 organization in determining whether to provide coverage to a small  
38 employer shall be applied uniformly among all small employers  
39 applying for coverage or receiving coverage from the carrier.

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

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

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

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

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

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

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

30 (7) This section applies only to grandfathered health plans as  
31 defined in RCW 48.43.005.

32 **PART III**

33 **GUARANTEED ISSUE AND ELIGIBILITY**

34 **Sec. 9.** RCW 48.43.012 and 2011 c 315 s 3 are each amended to  
35 read as follows:

36 (1) No carrier may reject an individual for an individual or  
37 group health benefit plan based upon preexisting conditions of the  
38 individual (~~except as provided in RCW 48.43.018~~).

1 (2) No carrier may deny, exclude, or otherwise limit coverage for  
2 an individual's preexisting health conditions (~~(except as provided in~~  
3 ~~this section)~~) including, but not limited to, preexisting condition  
4 exclusions or waiting periods.

5 ~~(3) ((For an individual health benefit plan originally issued on~~  
6 ~~or after March 23, 2000, preexisting condition waiting periods~~  
7 ~~imposed upon a person enrolling in an individual health benefit plan~~  
8 ~~shall be no more than nine months for a preexisting condition for~~  
9 ~~which medical advice was given, for which a health care provider~~  
10 ~~recommended or provided treatment, or for which a prudent layperson~~  
11 ~~would have sought advice or treatment, within six months prior to the~~  
12 ~~effective date of the plan. No carrier may impose a preexisting~~  
13 ~~condition waiting period on an individual health benefit plan issued~~  
14 ~~to an eligible individual as defined in section 2741(b) of the~~  
15 ~~federal health insurance portability and accountability act of 1996~~  
16 ~~(42 U.S.C. 300gg-41(b)).~~

17 ~~(4) Individual health benefit plan preexisting condition waiting~~  
18 ~~periods shall not apply to prenatal care services.~~

19 ~~(5))~~) No carrier may avoid the requirements of this section  
20 through the creation of a new rate classification or the modification  
21 of an existing rate classification. A new or changed rate  
22 classification will be deemed an attempt to avoid the provisions of  
23 this section if the new or changed classification would substantially  
24 discourage applications for coverage from individuals who are higher  
25 than average health risks. These provisions apply only to individuals  
26 who are Washington residents.

27 ~~((6) For any person under age nineteen applying for coverage as~~  
28 ~~allowed by RCW 48.43.0122(1) or enrolled in a health benefit plan~~  
29 ~~subject to sections 1201 and 10103 of the patient protection and~~  
30 ~~affordable care act (P.L. 111-148) that is not a grandfathered health~~  
31 ~~plan in the individual market, a carrier must not impose a~~  
32 ~~preexisting condition exclusion or waiting period or other~~  
33 ~~limitations on benefits or enrollment due to a preexisting~~  
34 ~~condition.))~~

35 (4) Unless preempted by federal law, the commissioner shall adopt  
36 any rules necessary to implement this section, consistent with  
37 federal rules and guidance in effect on January 1, 2017, implementing  
38 the patient protection and affordable care act.

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

3        (1) A health carrier or health plan may not establish rules for  
4    eligibility, including continued eligibility, of any individual to  
5    enroll under the terms of the plan or coverage based on any of the  
6    following health status-related factors in relation to the individual  
7    or a dependent of the individual:

8        (a) Health status;

9        (b) Medical condition, including both physical and mental  
10    illnesses;

11       (c) Claims experience;

12       (d) Receipt of health care;

13       (e) Medical history;

14       (f) Genetic information;

15       (g) Evidence of insurability, including conditions arising out of  
16    acts of domestic violence;

17       (h) Disability; or

18       (i) Any other health status-related factor determined appropriate  
19    by the commissioner.

20       (2) Unless preempted by federal law, the commissioner shall adopt  
21    any rules necessary to implement this section, consistent with  
22    federal rules and guidance in effect on January 1, 2017, implementing  
23    the patient protection and affordable care act.

24       **Sec. 11.**    RCW 48.21.270 and 2011 c 314 s 2 are each amended to  
25    read as follows:

26       (1) An insurer shall not require proof of insurability as a  
27    condition for issuance of the conversion policy.

28       (2) A conversion policy may not contain an exclusion for  
29    preexisting conditions for any applicant (~~who is under age nineteen.~~  
30    ~~For policies issued to those age nineteen and older, an exclusion for~~  
31    ~~a preexisting condition is permitted only to the extent that a~~  
32    ~~waiting period for a preexisting condition has not been satisfied~~  
33    ~~under the group policy)).~~

34       (3) An insurer must offer at least three policy benefit plans  
35    that comply with the following:

36       (a) A major medical plan with a five thousand dollar deductible  
37    per person;

38       (b) A comprehensive medical plan with a five hundred dollar  
39    deductible per person; and

1 (c) A basic medical plan with a one thousand dollar deductible  
2 per person.

3 (4) The insurance commissioner may revise the deductible amounts  
4 in subsection (3) of this section from time to time to reflect  
5 changing health care costs.

6 (5) The insurance commissioner shall adopt rules to establish  
7 minimum benefit standards for conversion policies.

8 (6) The commissioner shall adopt rules to establish specific  
9 standards for conversion policy provisions. These rules may include  
10 but are not limited to:

11 (a) Terms of renewability;

12 (b) Nonduplication of coverage;

13 (c) Benefit limitations, exceptions, and reductions; and

14 (d) Definitions of terms.

15 **Sec. 12.** RCW 48.44.380 and 2011 c 314 s 7 are each amended to  
16 read as follows:

17 (1) A health care service contractor shall not require proof of  
18 insurability as a condition for issuance of the conversion contract.

19 (2) A conversion contract may not contain an exclusion for  
20 preexisting conditions for any applicant (~~(who is under age nineteen.~~  
21 ~~For policies issued to those age nineteen and older, an exclusion for~~  
22 ~~a preexisting condition is permitted only to the extent that a~~  
23 ~~waiting period for a preexisting condition has not been satisfied~~  
24 ~~under the group contract)).~~

25 (3) A health care service contractor must offer at least three  
26 contract benefit plans that comply with the following:

27 (a) A major medical plan with a five thousand dollar deductible  
28 per person;

29 (b) A comprehensive medical plan with a five hundred dollar  
30 deductible per person; and

31 (c) A basic medical plan with a one thousand dollar deductible  
32 per person.

33 (4) The insurance commissioner may revise the deductible amounts  
34 in subsection (3) of this section from time to time to reflect  
35 changing health care costs.

36 (5) The insurance commissioner shall adopt rules to establish  
37 minimum benefit standards for conversion contracts.

1 (6) The commissioner shall adopt rules to establish specific  
2 standards for conversion contract provisions. These rules may include  
3 but are not limited to:

- 4 (a) Terms of renewability;
- 5 (b) Nonduplication of coverage;
- 6 (c) Benefit limitations, exceptions, and reductions; and
- 7 (d) Definitions of terms.

8 **Sec. 13.** RCW 48.46.460 and 2011 c 314 s 9 are each amended to  
9 read as follows:

10 (1) A health maintenance organization must offer a conversion  
11 agreement for comprehensive health care services and shall not  
12 require proof of insurability as a condition for issuance of the  
13 conversion agreement.

14 (2) A conversion agreement may not contain an exclusion for  
15 preexisting conditions for an applicant (~~who is under age nineteen.~~  
16 ~~For policies issued to those age nineteen and older, an exclusion for~~  
17 ~~a preexisting condition is permitted only to the extent that a~~  
18 ~~waiting period for a preexisting condition has not been satisfied~~  
19 ~~under the group agreement)).~~

20 (3) A conversion agreement need not provide benefits identical to  
21 those provided under the group agreement. The conversion agreement  
22 may contain provisions requiring the person covered by the conversion  
23 agreement to pay reasonable deductibles and copayments, except for  
24 preventive service benefits as defined in 45 C.F.R. 147.130 (2010),  
25 implementing sections 2701 through 2763, 2791, and 2792 of the public  
26 health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and  
27 300gg-92), as amended.

28 (4) The insurance commissioner shall adopt rules to establish  
29 minimum benefit standards for conversion agreements.

30 (5) The commissioner shall adopt rules to establish specific  
31 standards for conversion agreement provisions. These rules may  
32 include but are not limited to:

- 33 (a) Terms of renewability;
- 34 (b) Nonduplication of coverage;
- 35 (c) Benefit limitations, exceptions, and reductions; and
- 36 (d) Definitions of terms.

37 NEW SECTION. **Sec. 14.** The following acts or parts of acts are  
38 each repealed:

1 (1) RCW 48.43.015 (Health benefit plans—Preexisting conditions)  
2 and 2012 c 64 s 2, 2004 c 192 s 5, 2001 c 196 s 7, 2000 c 80 s 3,  
3 2000 c 79 s 20, & 1995 c 265 s 5;

4 (2) RCW 48.43.017 (Organ transplant benefit waiting periods—Prior  
5 creditable coverage) and 2009 c 82 s 2;

6 (3) RCW 48.43.018 (Requirement to complete the standard health  
7 questionnaire—Exemptions—Results) and 2012 c 211 s 16, 2012 c 64 s  
8 1, 2010 c 277 s 1, & 2009 c 42 s 1; and

9 (4) RCW 48.43.025 (Group health benefit plans—Preexisting  
10 conditions) and 2001 c 196 s 9, 2000 c 79 s 23, & 1995 c 265 s 6.

11 **PART IV**

12 **PROHIBITING UNFAIR RESCISSIONS**

13 NEW SECTION. **Sec. 15.** A new section is added to chapter 48.43  
14 RCW to read as follows:

15 (1) A health plan or health carrier offering group or individual  
16 coverage may not rescind such coverage with respect to an enrollee  
17 once the enrollee is covered under the plan or coverage involved,  
18 except that this section does not apply to a covered person who has  
19 performed an act or practice that constitutes fraud or makes an  
20 intentional misrepresentation of material fact as prohibited by the  
21 terms of the plan or coverage. The plan or coverage may not be  
22 canceled except as permitted under RCW 48.43.035 or 48.43.038.

23 (2) The commissioner shall adopt any rules necessary to implement  
24 this section, consistent with federal rules and guidance in effect on  
25 January 1, 2017, implementing the patient protection and affordable  
26 care act.

27 **PART V**

28 **ESSENTIAL HEALTH BENEFITS**

29 **Sec. 16.** RCW 48.43.715 and 2013 c 325 s 1 are each amended to  
30 read as follows:

31 ((Consistent with federal law,)) The commissioner, in  
32 consultation with the board and the health care authority, shall, by  
33 rule, select the largest small group plan in the state by enrollment  
34 as the benchmark plan for the individual and small group market for

1 purposes of establishing the essential health benefits in Washington  
2 state (~~under P.L. 111-148 of 2010, as amended~~)).

3 (2) If the essential health benefits benchmark plan for the  
4 individual and small group market does not include all of the ten  
5 essential health benefits categories (~~specified by section 1302 of~~  
6 ~~P.L. 111-148, as amended~~), the commissioner, in consultation with  
7 the board and the health care authority, shall, by rule, supplement  
8 the benchmark plan benefits as needed (~~to meet the minimum~~  
9 ~~requirements of section 1302~~)).

10 (3) ((A)) All individual and small group health plans (~~required~~  
11 ~~to offer~~) must cover the ten essential health benefits categories,  
12 other than a health plan offered through the federal basic health  
13 program, a grandfathered health plan, or medicaid(~~(, under P.L.~~  
14 ~~111-148 of 2010, as amended,~~)). Such a health plan may not be offered  
15 in the state unless the commissioner finds that it is substantially  
16 equal to the benchmark plan. When making this determination, the  
17 commissioner:

18 (a) Must ensure that the plan covers the ten essential health  
19 benefits categories (~~specified in section 1302 of P.L. 111-148 of~~  
20 ~~2010, as amended~~));

21 (b) May consider whether the health plan has a benefit design  
22 that would create a risk of biased selection based on health status  
23 and whether the health plan contains meaningful scope and level of  
24 benefits in each of the ten essential health benefits categories  
25 (~~specified by section 1302 of P.L. 111-148 of 2010, as amended~~));

26 (c) Notwithstanding (~~the foregoing~~) (a) and (b) of this  
27 subsection, for benefit years beginning January 1, 2015, (~~and only~~  
28 ~~to the extent permitted by federal law and guidance,~~) must establish  
29 by rule the review and approval requirements and procedures for  
30 pediatric oral services when offered in stand-alone dental plans in  
31 the nongrandfathered individual and small group markets outside of  
32 the exchange; and

33 (d) (~~Unless prohibited by federal law and guidance,~~) Must allow  
34 health carriers to also offer pediatric oral services within the  
35 health benefit plan in the nongrandfathered individual and small  
36 group markets outside of the exchange.

37 (4) Beginning December 15, 2012, and every year thereafter, the  
38 commissioner shall submit to the legislature a list of state-mandated  
39 health benefits, the enforcement of which will result in federally  
40 imposed costs to the state related to the plans sold through the



1 exchange because the benefits are not included in the essential  
2 health benefits designated under federal law. The list must include  
3 the anticipated costs to the state of each state-mandated health  
4 benefit on the list and any statutory changes needed if funds are not  
5 appropriated to defray the state costs for the listed mandate. The  
6 commissioner may enforce a mandate on the list for the entire market  
7 only if funds are appropriated in an omnibus appropriations act  
8 specifically to pay the state portion of the identified costs.

9 **PART VI**  
10 **COST SHARING**

11 NEW SECTION. **Sec. 17.** A new section is added to chapter 48.43  
12 RCW to read as follows:

13 (1) For plan years beginning in 2020, the cost sharing incurred  
14 under a health plan for the essential health benefits may not exceed  
15 the following amounts:

16 (a) For self-only coverage:

17 (i) The amount required under federal law for the calendar year;

18 or

19 (ii) If there are no cost-sharing requirements under federal law,  
20 eight thousand two hundred dollars increased by the premium  
21 adjustment percentage for the calendar year.

22 (b) For coverage other than self-only coverage:

23 (i) The amount required under federal law for the calendar year;

24 or

25 (ii) If there are no cost-sharing requirements under federal law,  
26 sixteen thousand four hundred dollars increased by the premium  
27 adjustment percentage for the calendar year.

28 (2) Regardless of whether an enrollee is covered by a self-only  
29 plan or a plan that is other than self-only, the enrollee's cost  
30 sharing for the essential health benefits may not exceed the self-  
31 only annual limitation on cost sharing.

32 (3) For purposes of this section, "the premium adjustment  
33 percentage for the calendar year" means the percentage, if any, by  
34 which the average per capita premium for health insurance in  
35 Washington for the preceding year, as estimated by the commissioner  
36 no later than April 1st of such preceding year, exceeds such average  
37 per capita premium for 2020 as determined by the commissioner.

1 (4) Unless preempted by federal law, the commissioner shall adopt  
2 any rules necessary to implement this section, consistent with  
3 federal rules and guidance in effect on January 1, 2017, implementing  
4 the patient protection and affordable care act.

5 **PART VII**

6 **OPEN ENROLLMENT PERIODS**

7 **Sec. 18.** RCW 48.43.0122 and 2011 c 315 s 4 are each amended to  
8 read as follows:

9 (1) The commissioner shall adopt rules establishing and  
10 implementing requirements for the open enrollment periods and special  
11 enrollment periods that carriers must follow for individual health  
12 benefit plans (~~and enrollment of persons under age nineteen~~).

13 (2) The commissioner shall monitor the sale of individual health  
14 benefit plans and if a carrier refuses to sell guaranteed issue  
15 policies to persons (~~under age nineteen~~) in compliance with rules  
16 adopted by the commissioner pursuant to subsection (1) of this  
17 section, the commissioner may levy fines or suspend or revoke a  
18 certificate of authority as provided in chapter 48.05 RCW.

19 **PART VIII**

20 **LIFETIME LIMITS**

21 NEW SECTION. **Sec. 19.** A new section is added to chapter 48.43  
22 RCW to read as follows:

23 A health carrier may not impose annual or lifetime dollar limits  
24 on an essential health benefit, other than those permitted as  
25 reference-based limitations under rules adopted by the commissioner.

26 **PART IX**

27 **MEDICAL LOSS RATIOS**

28 NEW SECTION. **Sec. 20.** A new section is added to chapter 48.43  
29 RCW to read as follows:

30 (1) A health carrier offering an individual or group health plan  
31 shall, with respect to each plan year, submit to the commissioner a  
32 report concerning the ratio of the incurred loss or incurred claims  
33 plus the loss adjustment expense or change in contract reserves to  
34 earned premiums. The report must include the percentage of total

1 premium revenue, after accounting for collections or receipts under  
2 the federal risk adjustment program, that the coverage expends:

3 (a) On reimbursement for clinical services provided to enrollees  
4 under the coverage;

5 (b) For activities that improve health care quality; and

6 (c) On all other nonclaims costs, including an explanation of the  
7 nature of the costs and excluding federal and state taxes and  
8 licensing or regulatory fees.

9 (2)(a) A health carrier offering an individual or group health  
10 plan shall, with respect to each plan year, provide an annual rebate  
11 to each enrollee under the health plan, on a pro rata basis, if the  
12 ratio of the amount of premium revenue expended by the carrier on  
13 costs described in subsection (1)(a) and (b) of this section to the  
14 total amount of premium revenue, excluding federal and state taxes  
15 and licensing or regulatory fees and after accounting for payments or  
16 receipts under the federal risk adjustment program, for the plan year  
17 is less than:

18 (i) Eighty-five percent for large group market health plans; or

19 (ii) Eighty percent for individual or small group market health  
20 plans.

21 (b) The determination made under this subsection must be based on  
22 the averages of the premiums expended on the costs and total premium  
23 revenue for each of the previous three years for the plan.

24 (3) The total amount of the rebate required under this section  
25 must be in an amount equal to the product of:

26 (a) The amount by which the percentage required under subsection  
27 (2)(a)(i) or (ii) of this section exceeds the ratio calculated under  
28 subsection (2)(a) of this section; and

29 (b) The total amount of premium revenue, excluding federal and  
30 state taxes and licensing or regulatory fees and after accounting for  
31 payments or receipts under the federal risk adjustment program, for  
32 the plan year.

33 (4) The commissioner may, by rule, increase the percentages  
34 required under subsection (2)(a)(i) and (ii) of this section. When  
35 determining the percentages, the commissioner must seek to ensure  
36 adequate participation by health carriers, competition in the health  
37 insurance market in the state, and value for consumers so that  
38 premiums are used for clinical services and quality improvements.

39 (5) When enforcing this section, the commissioner shall use  
40 definitions established by the national association of insurance

1 commissioners to implement 42 U.S.C. Sec. 300gg-18 as it existed on  
2 the effective date of this section. The commissioner shall, by rule,  
3 adopt changes to the definitions based on changes made by the  
4 national association of insurance commissioners.

5 (6) Unless preempted by federal law, the commissioner shall adopt  
6 any rules necessary to implement this section, consistent with  
7 federal rules and guidance in effect on January 1, 2017, implementing  
8 the patient protection and affordable care act.

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

11 (1) RCW 48.20.025 (Schedule of rates for individual health  
12 benefit plans—Loss ratio—Definitions) and 2011 c 314 s 10, 2008 c  
13 303 s 4, 2003 c 248 s 8, 2001 c 196 s 1, & 2000 c 79 s 3;

14 (2) RCW 48.44.017 (Schedule of rates for individual contracts—  
15 Loss ratio—Definitions) and 2011 c 314 s 11, 2008 c 303 s 5, 2001 c  
16 196 s 11, & 2000 c 79 s 29; and

17 (3) RCW 48.46.062 (Schedule of rates for individual agreements—  
18 Loss ratio—Definitions) and 2011 c 314 s 12, 2008 c 303 s 6, 2001 c  
19 196 s 12, & 2000 c 79 s 32.

## 20 **PART X**

### 21 **EXPLANATION OF COVERAGE**

22 NEW SECTION. **Sec. 22.** A new section is added to chapter 48.43  
23 RCW to read as follows:

24 (1) The commissioner shall develop standards for use by a health  
25 carrier offering individual or group coverage, in compiling and  
26 providing to applicants and enrollees a summary of benefits and  
27 coverage explanation that accurately describes the benefits and  
28 coverage under the applicable plan. In developing the standards, the  
29 commissioner must use the standards developed under 42 U.S.C. Sec.  
30 300gg-15 in use on the effective date of this section.

31 (2) The standards must provide for the following:

32 (a) The standards must ensure that the summary of benefits and  
33 coverage is presented in a uniform format that does not exceed four  
34 pages in length and does not include print smaller than twelve-point  
35 font.

1 (b) The standards must ensure that the summary is presented in a  
2 culturally and linguistically appropriate manner and utilizes  
3 terminology understandable by the average plan enrollee.

4 (c) The standards must ensure that the summary of benefits and  
5 coverage includes:

6 (i) Uniform definitions of standard insurance and medical terms,  
7 consistent with the standard definitions developed under this  
8 section, so that consumers may compare health insurance coverage and  
9 understand the terms of coverage, or exceptions to such coverage;

10 (ii) A description of the coverage, including cost sharing for:

11 (A) The essential health benefits; and

12 (B) Other benefits identified by the commissioner;

13 (iii) The exceptions, reductions, and limitations on coverage;

14 (iv) The cost-sharing provisions, including deductible,  
15 coinsurance, and copayment obligations;

16 (v) The renewability and continuation of coverage provisions;

17 (vi) A coverage facts label that includes examples to illustrate  
18 common benefits scenarios, including pregnancy and serious or chronic  
19 medical conditions and related cost sharing. The scenarios must be  
20 based on recognized clinical practice guidelines;

21 (vii) A statement of whether the plan:

22 (A) Provides minimum essential coverage under 26 U.S.C. Sec.  
23 5000A(f); and

24 (B) Ensures that the plan share of the total allowed costs of  
25 benefits provided under the plan is no less than sixty percent of the  
26 costs;

27 (viii) A statement that the outline is a summary of the policy or  
28 certificate and that the coverage document itself should be consulted  
29 to determine the governing contractual provisions; and

30 (ix) A contact number for the consumer to call with additional  
31 questions and a web site where a copy of the actual individual  
32 coverage policy or group certificate of coverage may be reviewed and  
33 obtained.

34 (3) The commissioner shall periodically review and update the  
35 standards developed under this section.

36 (4) A health carrier must provide a summary of benefits and  
37 coverage explanation to:

38 (a) An applicant at the time of application;

39 (b) An enrollee prior to the time of enrollment or reenrollment,  
40 as applicable; and

1 (c) A policyholder or certificate holder at the time of issuance  
2 of the policy or delivery of the certificate.

3 (5) A health carrier may provide the summary of benefits and  
4 coverage either in paper or electronically.

5 (6) If a health carrier makes any material modification in any of  
6 the terms of the plan that is not reflected in the most recently  
7 provided summary of benefits and coverage, the carrier shall provide  
8 notice of the modification to enrollees no later than sixty days  
9 prior to the date on which the modification will become effective.

10 (7) A health carrier that fails to provide the information  
11 required under this section is subject to a fine of no more than one  
12 thousand dollars for each failure. A failure with respect to each  
13 enrollee constitutes a separate offense for purposes of this  
14 subsection.

15 (8) The commissioner shall, by rule, provide for the development  
16 of standards for the definitions of terms used in health insurance  
17 coverage, including the following:

18 (a) Insurance-related terms, including premium; deductible;  
19 coinsurance; copayment; out-of-pocket limit; preferred provider;  
20 nonpreferred provider; out-of-network copayments; usual, customary,  
21 and reasonable fees; excluded services; grievance; appeals; and any  
22 other terms the commissioner determines are important to define so  
23 that consumers may compare health insurance coverage and understand  
24 the terms of their coverage; and

25 (b) Medical terms, including hospitalization, hospital outpatient  
26 care, emergency room care, physician services, prescription drug  
27 coverage, durable medical equipment, home health care, skilled  
28 nursing care, rehabilitation services, hospice services, emergency  
29 medical transportation, and any other terms the commissioner  
30 determines are important to define so that consumers may compare the  
31 medical benefits offered by health insurance and understand the  
32 extent of those medical benefits or exceptions to those benefits.

33 (9) Unless preempted by federal law, the commissioner shall adopt  
34 any rules necessary to implement this section, consistent with  
35 federal rules and guidance in effect on January 1, 2017, implementing  
36 the patient protection and affordable care act.

37 **PART XI**

38 **WAITING PERIODS FOR GROUP COVERAGE**

1        NEW SECTION.    **Sec. 23.**    A new section is added to chapter 48.43  
2    RCW to read as follows:

3        (1) A group health plan and a health carrier offering group  
4    health coverage may not apply any waiting period that exceeds ninety  
5    days.

6        (2) Unless preempted by federal law, the commissioner shall adopt  
7    any rules necessary to implement this section, consistent with  
8    federal rules and guidance in effect on January 1, 2017, implementing  
9    the patient protection and affordable care act.

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