2SSB 5945 - H AMD **607**
By Representative Ericksen

SCOPE AND OBJECT 04/16/2009

Strike everything after the enacting clause and insert the following:

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

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

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

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

(2) The legislature intends to:

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

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

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

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

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

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

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

(b) The insurance commissioner;

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

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

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

(f) Employer and consumer representatives.

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

(1)((~~(a)~~)) An insurer 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 an insurer 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. An insurer 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 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.~~

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

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

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

(3) Nothing in this section shall prohibit an insurer 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)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

(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~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, 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 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.~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, 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 eight percentage points are subject to review by the commissioner, and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time 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)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

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

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

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

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

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

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

(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)~~)) (7) 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)~~)) (8) 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. 4. 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~~)) no more than one 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)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.44.210, 48.44.212, 48.44.225, 48.44.240 through 48.44.245, 48.44.290 through 48.44.341, 48.44.344, 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

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

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

(3) 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)~~)) (4) 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)~~)) (4).

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

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

(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~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, 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~~)) eight 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~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, 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 eight percentage points are subject to review by the commissioner, and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time 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)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

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

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

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

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

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

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

(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)~~)) (7) 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. 5. 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~~)) no more than one 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 benefit plan under this subsection shall~~

~~clearly disclose all the 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 48.46.275, 48.46.280, 48.46.285, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.~~

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

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

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

(3) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the 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)~~)) (4) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

(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~~)) for a plan. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, 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~~)) eight 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~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, 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 health maintenance organization's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner, and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time 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)~~)) (5) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (6)(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)~~)) (7) 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.

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

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

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

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

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

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

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

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

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

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

(c) Which allows contributions from more than one employer to be used towards the purchase of an individual's health benefit plan;

shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. All such rates shall conform to the following:

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

(A) Geographic area;

(B) Family size;

(C) Age;

(D) Tenure discounts; and

(E) Wellness activities.

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

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

(iv) Except as provided in subsection (2) of this section, 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.

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

(vi) 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:

(A) Changes to the family composition;

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

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

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

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

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

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

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

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

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

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

(1) "Commissioner" means the insurance commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The commissioner shall establish by rule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Correct the title.

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