

ESSB 6538 - H AMD 1529

By Representative Cody

ADOPTED 03/09/2010

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

3 "Sec. 1. RCW 48.43.005 and 2008 c 145 s 20 and 2008 c 144 s 1 are
4 each reenacted and amended to read as follows:

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

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

11 (2) "Basic health plan" means the plan described under chapter
12 70.47 RCW, as revised from time to time.

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

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

19 (5) "Catastrophic health plan" means:

20 (a) In the case of a contract, agreement, or policy covering a
21 single enrollee, a health benefit plan requiring a calendar year
22 deductible of, at a minimum, one thousand seven hundred fifty dollars
23 and an annual out-of-pocket expense required to be paid under the plan
24 (other than for premiums) for covered benefits of at least three
25 thousand five hundred dollars, both amounts to be adjusted annually by
26 the insurance commissioner; and

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

1 than for premiums) for covered benefits of at least six thousand
2 dollars, both amounts to be adjusted annually by the insurance
3 commissioner; or

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

9 In July 2008, and in each July thereafter, the insurance
10 commissioner shall adjust the minimum deductible and out-of-pocket
11 expense required for a plan to qualify as a catastrophic plan to
12 reflect the percentage change in the consumer price index for medical
13 care for a preceding twelve months, as determined by the United States
14 department of labor. The adjusted amount shall apply on the following
15 January 1st.

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

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

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

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

31 (10) "Employee" has the same meaning given to the term, as of
32 January 1, 2008, under section 3(6) of the federal employee retirement
33 income security act of 1974.

34 (11) "Emergency medical condition" means the emergent and acute
35 onset of a symptom or symptoms, including severe pain, that would lead
36 a prudent layperson acting reasonably to believe that a health
37 condition exists that requires immediate medical attention, if failure

1 to provide medical attention would result in serious impairment to
2 bodily functions or serious dysfunction of a bodily organ or part, or
3 would place the person's health in serious jeopardy.

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

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

11 (14) "Grievance" means a written complaint submitted by or on
12 behalf of a covered person regarding: (a) Denial of payment for
13 medical services or nonprovision of medical services included in the
14 covered person's health benefit plan, or (b) service delivery issues
15 other than denial of payment for medical services or nonprovision of
16 medical services, including dissatisfaction with medical care, waiting
17 time for medical services, provider or staff attitude or demeanor, or
18 dissatisfaction with service provided by the health carrier.

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

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

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

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

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

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

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

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

13 (b) Medicare supplemental health insurance governed by chapter
14 48.66 RCW;

15 (c) Coverage supplemental to the coverage provided under chapter
16 55, Title 10, United States Code;

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

19 (e) Disability income;

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

23 (g) Workers' compensation coverage;

24 (h) Accident only coverage;

25 (i) Specified disease or illness-triggered fixed payment insurance,
26 hospital confinement fixed payment insurance, or other fixed payment
27 insurance offered as an independent, noncoordinated benefit;

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

29 (k) Dental only and vision only coverage; and

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

37 (20) "Material modification" means a change in the actuarial value

1 of the health plan as modified of more than five percent but less than
2 fifteen percent.

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

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

13 (23) "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 defined
16 in RCW 48.46.020, and entities affiliated with, under contract with, or
17 acting on behalf of a health carrier to perform a utilization review.

18 (24) "Small employer" or "small group" means any person, firm,
19 corporation, partnership, association, political subdivision, sole
20 proprietor, or self-employed individual that is actively engaged in
21 business that employed an average of at least ~~((two))~~ one but no more
22 than fifty employees, during the previous calendar year and employed at
23 least ~~((two))~~ one employee~~((s))~~ on the first day of the plan year, is
24 not formed primarily for purposes of buying health insurance, and in
25 which a bona fide employer-employee relationship exists. In
26 determining the number of employees, companies that are affiliated
27 companies, or that are eligible to file a combined tax return for
28 purposes of taxation by this state, shall be considered an employer.
29 Subsequent to the issuance of a health plan to a small employer and for
30 the purpose of determining eligibility, the size of a small employer
31 shall be determined annually. Except as otherwise specifically
32 provided, a small employer shall continue to be considered a small
33 employer until the plan anniversary following the date the small
34 employer no longer meets the requirements of this definition. A self-
35 employed individual or sole proprietor ~~((who is covered as a group of~~
36 ~~one on the day prior to June 10, 2004, shall also be considered a~~
37 ~~"small employer" to the extent that individual or group of one is~~
38 ~~entitled to have his or her coverage renewed as provided in RCW~~

1 48.43.035(6)) who is covered as a group of one must also: (a) Have
2 been employed by the same small employer or small group for at least
3 twelve months prior to application for small group coverage, and (b)
4 verify that he or she derived at least seventy-five percent of his or
5 her income from a trade or business through which the individual or
6 sole proprietor has attempted to earn taxable income and for which he
7 or she has filed the appropriate internal revenue service form 1040,
8 schedule C or F, for the previous taxable year, except a self-employed
9 individual or sole proprietor in an agricultural trade or business,
10 must have derived at least fifty-one percent of his or her income from
11 the trade or business through which the individual or sole proprietor
12 has attempted to earn taxable income and for which he or she has filed
13 the appropriate internal revenue service form 1040, for the previous
14 taxable year.

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

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

27 **Sec. 2.** RCW 48.43.035 and 2004 c 244 s 4 are each amended to read
28 as follows:

29 For group health benefit plans, the following shall apply:

30 (1) All health carriers shall accept for enrollment any state
31 resident within the group to whom the plan is offered and within the
32 carrier's service area and provide or assure the provision of all
33 covered services regardless of age, sex, family structure, ethnicity,
34 race, health condition, geographic location, employment status,
35 socioeconomic status, other condition or situation, or the provisions
36 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
37 exemption from this subsection, if, upon application by a health

1 carrier the commissioner finds that the clinical, financial, or
2 administrative capacity to serve existing enrollees will be impaired if
3 a health carrier is required to continue enrollment of additional
4 eligible individuals.

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

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

- 16 (a) Nonpayment of premium;
- 17 (b) Violation of published policies of the carrier approved by the
18 insurance commissioner;
- 19 (c) Covered persons entitled to become eligible for medicare
20 benefits by reason of age who fail to apply for a medicare supplement
21 plan or medicare cost, risk, or other plan offered by the carrier
22 pursuant to federal laws and regulations;
- 23 (d) Covered persons who fail to pay any deductible or copayment
24 amount owed to the carrier and not the provider of health care
25 services;
- 26 (e) Covered persons committing fraudulent acts as to the carrier;
- 27 (f) Covered persons who materially breach the health plan; or
- 28 (g) Change or implementation of federal or state laws that no
29 longer permit the continued offering of such coverage.

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

- 32 (a) A carrier has zero enrollment on a product;
- 33 (b) A carrier replaces a product and the replacement product is
34 provided to all covered persons within that class or line of business,
35 includes all of the services covered under the replaced product, and
36 does not significantly limit access to the kind of services covered
37 under the replaced product. The health plan may also allow
38 unrestricted conversion to a fully comparable product;

1 (c) No sooner than January 1, 2005, a carrier discontinues offering
2 a particular type of health benefit plan offered for groups of up to
3 two hundred if: (i) The carrier provides notice to each group of the
4 discontinuation at least ninety days prior to the date of the
5 discontinuation; (ii) the carrier offers to each group provided
6 coverage of this type the option to enroll, with regard to small
7 employer groups, in any other small employer group plan, or with regard
8 to groups of up to two hundred, in any other applicable group plan,
9 currently being offered by the carrier in the applicable group market;
10 and (iii) in exercising the option to discontinue coverage of this type
11 and in offering the option of coverage under (c)(ii) of this
12 subsection, the carrier acts uniformly without regard to any health
13 status-related factor of enrolled individuals or individuals who may
14 become eligible for this coverage;

15 (d) A carrier discontinues offering all health coverage in the
16 small group market or for groups of up to two hundred, or both markets,
17 in the state and discontinues coverage under all existing group health
18 benefit plans in the applicable market involved if: (i) The carrier
19 provides notice to the commissioner of its intent to discontinue
20 offering all such coverage in the state and its intent to discontinue
21 coverage under all such existing health benefit plans at least one
22 hundred eighty days prior to the date of the discontinuation of
23 coverage under all such existing health benefit plans; and (ii) the
24 carrier provides notice to each covered group of the intent to
25 discontinue the existing health benefit plan at least one hundred
26 eighty days prior to the date of discontinuation. In the case of
27 discontinuation under this subsection, the carrier may not issue any
28 group health coverage in this state in the applicable group market
29 involved for a five-year period beginning on the date of the
30 discontinuation of the last health benefit plan not so renewed. This
31 subsection (4) does not require a carrier to provide notice to the
32 commissioner of its intent to discontinue offering a health benefit
33 plan to new applicants when the carrier does not discontinue coverage
34 of existing enrollees under that health benefit plan; or

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

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

6 ~~((6) Notwithstanding any other provision of this section, the
7 guarantee of continuity of coverage applies to a group of one only if:
8 (a) The carrier continues to offer any other small employer group plan
9 in which the group of one was eligible to enroll on the day prior to
10 June 10, 2004; and (b) the person continues to qualify as a group of
11 one under the criteria in place on the day prior to June 10, 2004.))~~

12 **Sec. 3.** RCW 48.44.010 and 2007 c 267 s 2 are each amended to read
13 as follows:

14 For the purposes of this chapter:

15 (1) "Health care services" means and includes medical, surgical,
16 dental, chiropractic, hospital, optometric, podiatric, pharmaceutical,
17 ambulance, custodial, mental health, and other therapeutic services.

18 (2) "Provider" means any health professional, hospital, or other
19 institution, organization, or person that furnishes health care
20 services and is licensed to furnish such services.

21 (3) "Health care service contractor" means any corporation,
22 cooperative group, or association, which is sponsored by or otherwise
23 intimately connected with a provider or group of providers, who or
24 which not otherwise being engaged in the insurance business, accepts
25 prepayment for health care services from or for the benefit of persons
26 or groups of persons as consideration for providing such persons with
27 any health care services. "Health care service contractor" does not
28 include direct patient-provider primary care practices as defined in
29 RCW 48.150.010.

30 (4) "Participating provider" means a provider, who or which has
31 contracted in writing with a health care service contractor to accept
32 payment from and to look solely to such contractor according to the
33 terms of the subscriber contract for any health care services rendered
34 to a person who has previously paid, or on whose behalf prepayment has
35 been made, to such contractor for such services.

36 (5) "Enrolled participant" means a person or group of persons who

1 have entered into a contractual arrangement or on whose behalf a
2 contractual arrangement has been entered into with a health care
3 service contractor to receive health care services.

4 (6) "Commissioner" means the insurance commissioner.

5 (7) "Uncovered expenditures" means the costs to the health care
6 service contractor for health care services that are the obligation of
7 the health care service contractor for which an enrolled participant
8 would also be liable in the event of the health care service
9 contractor's insolvency and for which no alternative arrangements have
10 been made as provided herein. The term does not include expenditures
11 for covered services when a provider has agreed not to bill the
12 enrolled participant even though the provider is not paid by the health
13 care service contractor, or for services that are guaranteed, insured
14 or assumed by a person or organization other than the health care
15 service contractor.

16 (8) "Copayment" means an amount specified in a group or individual
17 contract which is an obligation of an enrolled participant for a
18 specific service which is not fully prepaid.

19 (9) "Deductible" means the amount an enrolled participant is
20 responsible to pay before the health care service contractor begins to
21 pay the costs associated with treatment.

22 (10) "Group contract" means a contract for health care services
23 which by its terms limits eligibility to members of a specific group.
24 The group contract may include coverage for dependents.

25 (11) "Individual contract" means a contract for health care
26 services issued to and covering an individual. An individual contract
27 may include dependents.

28 (12) "Carrier" means a health maintenance organization, an insurer,
29 a health care service contractor, or other entity responsible for the
30 payment of benefits or provision of services under a group or
31 individual contract.

32 (13) "Replacement coverage" means the benefits provided by a
33 succeeding carrier.

34 (14) "Insolvent" or "insolvency" means that the organization has
35 been declared insolvent and is placed under an order of liquidation by
36 a court of competent jurisdiction.

37 (15) "Fully subordinated debt" means those debts that meet the
38 requirements of RCW 48.44.037(3) and are recorded as equity.

1 (16) "Net worth" means the excess of total admitted assets as
2 defined in RCW 48.12.010 over total liabilities but the liabilities
3 shall not include fully subordinated debt.

4 (17) "Census date" means the date upon which a health care services
5 contractor offering coverage to a small employer must base rate
6 calculations. For a small employer applying for a health benefit plan
7 through a contractor other than its current contractor, the census date
8 is the date that final group composition is received by the contractor.
9 For a small employer that is renewing its health benefit plan through
10 its existing contractor, the census date is ninety days prior to the
11 effective date of the renewal.

12 **Sec. 4.** RCW 48.44.023 and 2009 c 131 s 2 are each amended to read
13 as follows:

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

26 (b) A health benefit plan offered under this subsection shall
27 provide coverage for hospital expenses and services rendered by a
28 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
29 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,
30 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,
31 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

32 (2) Nothing in this section shall prohibit a health care service
33 contractor from offering, or a purchaser from seeking, health benefit
34 plans with benefits in excess of the health benefit plan offered under
35 subsection (1) of this section. All forms, policies, and contracts
36 shall be submitted for approval to the commissioner, and the rates of

1 any plan offered under this section shall be reasonable in relation to
2 the benefits thereto.

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

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

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

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

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

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

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

1 also work with the carrier to develop a wellness program and a means to
2 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 48.44.010, rating factors
13 shall produce premiums for identical groups that differ only by the
14 amounts attributable to plan design, and differences in census date
15 between new and renewal groups, with the exception of discounts for
16 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 similar
19 coverage to a health benefit plan that does not contain such a
20 provision, provided that the restrictions of benefits to network
21 providers result in substantial differences in claims costs. A carrier
22 may develop its rates based on claims costs due to network provider
23 reimbursement schedules or type of network. This subsection does not
24 restrict or enhance the portability of benefits as provided in RCW
25 48.43.015.

26 (i) Adjusted community rates established under this section shall
27 pool the medical experience of all 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 to
31 plus or minus four percentage points from the overall adjustment of a
32 carrier's entire small group pool, such overall adjustment to be
33 approved by the commissioner, upon a showing by the carrier, certified
34 by a member of the American academy of actuaries that: (i) The
35 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.

1 Variations of greater than four percentage points are subject to review
2 by the commissioner, and must be approved or denied within sixty days
3 of submittal. A variation that is not denied within sixty days shall
4 be deemed approved. The commissioner must provide to the carrier a
5 detailed actuarial justification for any denial within thirty days of
6 the denial.

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

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

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

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

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

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

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

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

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

37 (c) In applying minimum participation requirements with respect to

1 a small employer, a small employer shall not consider employees or
2 dependents who have similar existing coverage in determining whether
3 the applicable percentage of participation is met.

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

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

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

21 **Sec. 5.** RCW 48.46.020 and 1990 c 119 s 1 are each amended to read
22 as follows:

23 As used in this chapter, the terms defined in this section shall
24 have the meanings indicated unless the context indicates otherwise.

25 (1) "Health maintenance organization" means any organization
26 receiving a certificate of registration by the commissioner under this
27 chapter which provides comprehensive health care services to enrolled
28 participants of such organization on a group practice per capita
29 prepayment basis or on a prepaid individual practice plan, except for
30 an enrolled participant's responsibility for copayments and/or
31 deductibles, either directly or through contractual or other
32 arrangements with other institutions, entities, or persons, and which
33 qualifies as a health maintenance organization pursuant to RCW
34 48.46.030 and 48.46.040.

35 (2) "Comprehensive health care services" means basic consultative,
36 diagnostic, and therapeutic services rendered by licensed health
37 professionals together with emergency and preventive care, inpatient

1 hospital, outpatient and physician care, at a minimum, and any
2 additional health care services offered by the health maintenance
3 organization.

4 (3) "Enrolled participant" means a person who or group of persons
5 which has entered into a contractual arrangement or on whose behalf a
6 contractual arrangement has been entered into with a health maintenance
7 organization to receive health care services.

8 (4) "Health professionals" means health care practitioners who are
9 regulated by the state of Washington.

10 (5) "Health maintenance agreement" means an agreement for services
11 between a health maintenance organization which is registered pursuant
12 to the provisions of this chapter and enrolled participants of such
13 organization which provides enrolled participants with comprehensive
14 health services rendered to enrolled participants by health
15 professionals, groups, facilities, and other personnel associated with
16 the health maintenance organization.

17 (6) "Consumer" means any member, subscriber, enrollee, beneficiary,
18 or other person entitled to health care services under terms of a
19 health maintenance agreement, but not including health professionals,
20 employees of health maintenance organizations, partners, or
21 shareholders of stock corporations licensed as health maintenance
22 organizations.

23 (7) "Meaningful role in policy making" means a procedure approved
24 by the commissioner which provides consumers or elected representatives
25 of consumers a means of submitting the views and recommendations of
26 such consumers to the governing board of such organization coupled with
27 reasonable assurance that the board will give regard to such views and
28 recommendations.

29 (8) "Meaningful grievance procedure" means a procedure for
30 investigation of consumer grievances in a timely manner aimed at mutual
31 agreement for settlement according to procedures approved by the
32 commissioner, and which may include arbitration procedures.

33 (9) "Provider" means any health professional, hospital, or other
34 institution, organization, or person that furnishes any health care
35 services and is licensed or otherwise authorized to furnish such
36 services.

37 (10) "Department" means the state department of social and health
38 services.

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

2 (12) "Group practice" means a partnership, association,
3 corporation, or other group of health professionals:

4 (a) The members of which may be individual health professionals,
5 clinics, or both individuals and clinics who engage in the coordinated
6 practice of their profession; and

7 (b) The members of which are compensated by a prearranged salary,
8 or by capitation payment or drawing account that is based on the number
9 of enrolled participants.

10 (13) "Individual practice health care plan" means an association of
11 health professionals in private practice who associate for the purpose
12 of providing prepaid comprehensive health care services on a fee-for-
13 service or capitation basis.

14 (14) "Uncovered expenditures" means the costs to the health
15 maintenance organization of health care services that are the
16 obligation of the health maintenance organization for which an enrolled
17 participant would also be liable in the event of the health maintenance
18 organization's insolvency and for which no alternative arrangements
19 have been made as provided herein. The term does not include
20 expenditures for covered services when a provider has agreed not to
21 bill the enrolled participant even though the provider is not paid by
22 the health maintenance organization, or for services that are
23 guaranteed, insured, or assumed by a person or organization other than
24 the health maintenance organization.

25 (15) "Copayment" means an amount specified in a subscriber
26 agreement which is an obligation of an enrolled participant for a
27 specific service which is not fully prepaid.

28 (16) "Deductible" means the amount an enrolled participant is
29 responsible to pay out-of-pocket before the health maintenance
30 organization begins to pay the costs associated with treatment.

31 (17) "Fully subordinated debt" means those debts that meet the
32 requirements of RCW 48.46.235(3) and are recorded as equity.

33 (18) "Net worth" means the excess of total admitted assets as
34 defined in RCW 48.12.010 over total liabilities but the liabilities
35 shall not include fully subordinated debt.

36 (19) "Participating provider" means a provider as defined in
37 subsection (9) of this section who contracts with the health
38 maintenance organization or with its contractor or subcontractor and

1 has agreed to provide health care services to enrolled participants
2 with an expectation of receiving payment, other than copayment or
3 deductible, directly or indirectly, from the health maintenance
4 organization.

5 (20) "Carrier" means a health maintenance organization, an insurer,
6 a health care services contractor, or other entity responsible for the
7 payment of benefits or provision of services under a group or
8 individual agreement.

9 (21) "Replacement coverage" means the benefits provided by a
10 succeeding carrier.

11 (22) "Insolvent" or "insolvency" means that the organization has
12 been declared insolvent and is placed under an order of liquidation by
13 a court of competent jurisdiction.

14 (23) "Census date" means the date upon which a health maintenance
15 organization offering coverage to a small employer must base rate
16 calculations. For a small employer applying for a health benefit plan
17 through a health maintenance organization other than its current health
18 maintenance organization, the census date is the date that final group
19 composition is received by the health maintenance organization. For a
20 small employer that is renewing its health benefit plan through its
21 existing health maintenance organization, the census date is ninety
22 days prior to the effective date of the renewal.

23 **Sec. 6.** RCW 48.46.066 and 2009 c 131 s 3 are each amended to read
24 as follows:

25 (1)(a) A health maintenance organization offering any health
26 benefit plan to a small employer, either directly or through an
27 association or member-governed group formed specifically for the
28 purpose of purchasing health care, may offer and actively market to the
29 small employer a health benefit plan featuring a limited schedule of
30 covered health care services. Nothing in this subsection shall
31 preclude a health maintenance organization from offering, or a small
32 employer from purchasing, other health benefit plans that may have more
33 comprehensive benefits than those included in the product offered under
34 this subsection. A health maintenance organization offering a health
35 benefit plan under this subsection shall clearly disclose all the
36 covered benefits to the small employer in a brochure filed with the
37 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 subject
4 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350,
5 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and
6 48.46.530.

7 (2) Nothing in this section shall prohibit a health maintenance
8 organization from offering, or a purchaser from seeking, health benefit
9 plans with benefits in excess of the health benefit plan offered under
10 subsection (1) of this section. All forms, policies, and contracts
11 shall be submitted for approval to the commissioner, and the rates of
12 any plan offered under this section shall be reasonable in relation to
13 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 which
30 medicare is not the primary payer. Both rates shall be subject to the
31 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 groups
34 on January 1, 1996, four hundred percent on January 1, 1997, and three
35 hundred seventy-five percent on January 1, 2000, and thereafter.

36 (e) A discount for wellness activities shall be permitted to
37 reflect actuarially justified differences in utilization or cost
38 attributed to such programs. Up to a twenty percent variance may be

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

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 enrollment of the small employer;
18 (ii) Changes to the family composition of the employee;
19 (iii) Changes to the health benefit plan requested by the small
20 employer; or
21 (iv) Changes in government requirements affecting the health
22 benefit plan.

23 (g) On the census date, as defined in RCW 48.46.020, rating factors
24 shall produce premiums for identical groups that differ only by the
25 amounts attributable to plan design, and differences in census date
26 between new and renewal groups, with the exception of discounts for
27 health improvement programs.

28 (h) For the purposes of this section, a health benefit plan that
29 contains a restricted network provision shall not be considered similar
30 coverage to a health benefit plan that does not contain such a
31 provision, provided that the restrictions of benefits to network
32 providers result in substantial differences in claims costs. A carrier
33 may develop its rates based on claims costs due to network provider
34 reimbursement schedules or type of network. This subsection does not
35 restrict or enhance the portability of benefits as provided in RCW
36 48.43.015.

37 (i) Adjusted community rates established under this section shall
38 pool the medical experience of all groups purchasing coverage,

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

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

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

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

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

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

37 (5)(a) Except as provided in this subsection and subsection (3)(g)
38 of this section, requirements used by a health maintenance organization

1 in determining whether to provide coverage to a small employer shall be
2 applied uniformly among all small employers applying for coverage or
3 receiving coverage from the carrier.

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

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

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

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

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

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

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

33 **Sec. 7.** RCW 48.21.045 and 2009 c 131 s 1 are each amended to read
34 as follows:

35 (1)(a) An insurer offering any health benefit plan to a small
36 employer, either directly or through an association or member-governed
37 group formed specifically for the purpose of purchasing health care,

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

9 (b) A health benefit plan offered under this subsection shall
10 provide coverage for hospital expenses and services rendered by a
11 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
12 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,
13 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,
14 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250,
15 48.21.300, 48.21.310, or 48.21.320.

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

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

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

- 27 (i) Geographic area;
- 28 (ii) Family size;
- 29 (iii) Age; and
- 30 (iv) Wellness activities.

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

35 (c) The insurer shall be permitted to develop separate rates for
36 individuals age sixty-five or older for coverage for which medicare is
37 the primary payer and coverage for which medicare is not the primary

1 payer. Both rates shall be subject to the requirements of this
2 subsection (3).

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

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

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

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

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

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

1 coverage to a health benefit plan that does not contain such a
2 provision, provided that the restrictions of benefits to network
3 providers result in substantial differences in claims costs. A carrier
4 may develop its rates based on claims costs due to network provider
5 reimbursement schedules or type of network. This subsection does not
6 restrict or enhance the portability of benefits as provided in RCW
7 48.43.015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 **Sec. 8.** RCW 48.21.047 and 2005 c 223 s 11 are each amended to read
7 as follows:

8 (1) An insurer may not offer any health benefit plan to any small
9 employer without complying with RCW 48.21.045(3).

10 (2) Employers purchasing health plans provided through associations
11 or through member-governed groups formed specifically for the purpose
12 of purchasing health care are not small employers and the plans are not
13 subject to RCW 48.21.045(3).

14 (3) For purposes of this section, "health benefit plan," "health
15 plan," and "small employer" mean the same as defined in RCW 48.43.005.

16 (4) For purposes of this section, "census date" has the same
17 meaning as defined in RCW 48.44.010.

18 NEW SECTION. **Sec. 9.** This act applies to policies issued or
19 renewed on or after January 1, 2011.

20 NEW SECTION. **Sec. 10.** If federal legislation that includes
21 guaranteed issue for individuals who purchase health coverage through
22 the individual or small group market has not been signed by the
23 President of the United States by December 31, 2010, sections 1 and 2
24 of this act are null and void.

25 NEW SECTION. **Sec. 11.** Sections 1 and 2 of this act take effect
26 one hundred eighty days after the date the insurance commissioner
27 certifies to the secretary of the senate, the chief clerk of the house
28 of representatives, and the code reviser's office that federal
29 legislation has been signed into law by the President of the United
30 States that includes guaranteed issue for individuals who purchase
31 health coverage through the individual or small group markets."

32 Correct the title.

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