H-4425.1

HOUSE BILL 2997

State of Washington 61st Legislature 2010 Regular Session

By Representatives Cody, Ericksen, Morrell, and Wallace

Read first time 01/20/10. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to determining the appropriate date of a small
2 employer group's composition for purposes of setting health benefit
3 plan premium rates; amending RCW 48.44.010, 48.44.023, 48.46.020,
4 48.46.066, 48.21.045, and 48.21.047; and creating a new section.

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

6 **Sec. 1.** RCW 48.44.010 and 2007 c 267 s 2 are each amended to read
7 as follows:
8 For the purposes of this chapter:
9 (1) "Health care services" means and includes medical, surgical,
10 dental, chiropractic, hospital, optometric, podiatric, pharmaceutical,
11 ambulance, custodial, mental health, and other therapeutic services.
12 (2) "Provider" means any health professional, hospital, or other
13 institution, organization, or person that furnishes health care
14 services and is licensed to furnish such services.
15 (3) "Health care service contractor" means any corporation,
16 cooperative group, or association, which is sponsored by or otherwise
17 intimately connected with a provider or group of providers, who or
18 which not otherwise being engaged in the insurance business, accepts
19 prepayment for health care services from or for the benefit of persons

1 or groups of persons as consideration for providing such persons with
2 any health care services. "Health care service contractor" does not
3 include direct patient-provider primary care practices as defined in
4 RCW 48.150.010.
5 (4) "Participating provider" means a provider, who or which has
6 contracted in writing with a health care service contractor to accept
7 payment from and to look solely to such contractor according to the
8 terms of the subscriber contract for any health care services rendered
9 to a person who has previously paid, or on whose behalf prepayment has
10 been made, to such contractor for such services.
11 (5) "Enrolled participant" means a person or group of persons who
12 have entered into a contractual arrangement or on whose behalf a
13 contractual arrangement has been entered into with a health care
14 service contractor to receive health care services.
15 (6) "Commissioner" means the insurance commissioner.
16 (7) "Uncovered expenditures" means the costs to the health care
17 service contractor for health care services that are the obligation of
18 the health care service contractor for which an enrolled participant
19 would also be liable in the event of the health care service
20 contractor's insolvency and for which no alternative arrangements have
21 been made as provided herein. The term does not include expenditures
22 for covered services when a provider has agreed not to bill the
23 enrolled participant even though the provider is not paid by the health
24 care service contractor, or for services that are guaranteed, insured
25 or assumed by a person or organization other than the health care
26 service contractor.
27 (8) "Copayment" means an amount specified in a group or individual
28 contract which is an obligation of an enrolled participant for a
29 specific service which is not fully prepaid.
30 (9) "Deductible" means the amount an enrolled participant is
31 responsible to pay before the health care service contractor begins to
32 pay the costs associated with treatment.
33 (10) "Group contract" means a contract for health care services
34 which by its terms limits eligibility to members of a specific group.
35 The group contract may include coverage for dependents.
36 (11) "Individual contract" means a contract for health care
37 services issued to and covering an individual. An individual contract
38 may include dependents.

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

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

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

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

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

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

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

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

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

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance

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

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

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

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

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

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

(5)(a) Except as provided in this subsection and subsection (3)(g) of this section, requirements used by a contractor in determining

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

4 (b) A contractor shall not require a minimum participation level
5 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 contractor may not increase any requirement for minimum
15 employee participation or modify any requirement for minimum employer
16 contribution applicable to a small employer at any time after the small
17 employer has been accepted for coverage.

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

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

31 **Sec. 3.** RCW 48.46.020 and 1990 c 119 s 1 are each amended to read
32 as follows:

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

35 (1) "Health maintenance organization" means any organization
36 receiving a certificate of registration by the commissioner under this
37 chapter which provides comprehensive health care services to enrolled

participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(2) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

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

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

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

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

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

1 (8) "Meaningful grievance procedure" means a procedure for
2 investigation of consumer grievances in a timely manner aimed at mutual
3 agreement for settlement according to procedures approved by the
4 commissioner, and which may include arbitration procedures.
5 (9) "Provider" means any health professional, hospital, or other
6 institution, organization, or person that furnishes any health care
7 services and is licensed or otherwise authorized to furnish such
8 services.
9 (10) "Department" means the state department of social and health
10 services.
11 (11) "Commissioner" means the insurance commissioner.
12 (12) "Group practice" means a partnership, association,
13 corporation, or other group of health professionals:
14 (a) The members of which may be individual health professionals,
15 clinics, or both individuals and clinics who engage in the coordinated
16 practice of their profession; and
17 (b) The members of which are compensated by a prearranged salary,
18 or by capitation payment or drawing account that is based on the number
19 of enrolled participants.
20 (13) "Individual practice health care plan" means an association of
21 health professionals in private practice who associate for the purpose
22 of providing prepaid comprehensive health care services on a fee-for-
23 service or capitation basis.
24 (14) "Uncovered expenditures" means the costs to the health
25 maintenance organization of health care services that are the
26 obligation of the health maintenance organization for which an enrolled
27 participant would also be liable in the event of the health maintenance
28 organization's insolvency and for which no alternative arrangements
29 have been made as provided herein. The term does not include
30 expenditures for covered services when a provider has agreed not to
31 bill the enrolled participant even though the provider is not paid by
32 the health maintenance organization, or for services that are
33 guaranteed, insured, or assumed by a person or organization other than
34 the health maintenance organization.
35 (15) "Copayment" means an amount specified in a subscriber
36 agreement which is an obligation of an enrolled participant for a
37 specific service which is not fully prepaid.

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

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

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

9 (19) "Participating provider" means a provider as defined in
10 subsection (9) of this section who contracts with the health
11 maintenance organization or with its contractor or subcontractor and
12 has agreed to provide health care services to enrolled participants
13 with an expectation of receiving payment, other than copayment or
14 deductible, directly or indirectly, from the health maintenance
15 organization.

16 (20) "Carrier" means a health maintenance organization, an insurer,
17 a health care services contractor, or other entity responsible for the
18 payment of benefits or provision of services under a group or
19 individual agreement.

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

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

25 (23) "Census date" means the date upon which a health maintenance
26 organization offering coverage to a small employer must base rate
27 calculations. For a small employer applying for a health benefit plan
28 through a health maintenance organization other than its current health
29 maintenance organization, the census date is the date that final group
30 composition is received by the health maintenance organization. For a
31 small employer that is renewing its health benefit plan through its
32 existing health maintenance organization, the census date is sixty days
33 prior to the effective date of the renewal.

34 **Sec. 4.** RCW 48.46.066 and 2009 c 131 s 3 are each amended to read
35 as follows:

36 (1)(a) A health maintenance organization offering any health
37 benefit plan to a small employer, either directly or through an

1 association or member-governed group formed specifically for the
2 purpose of purchasing health care, may offer and actively market to the
3 small employer a health benefit plan featuring a limited schedule of
4 covered health care services. Nothing in this subsection shall
5 preclude a health maintenance organization from offering, or a small
6 employer from purchasing, other health benefit plans that may have more
7 comprehensive benefits than those included in the product offered under
8 this subsection. A health maintenance organization offering a health
9 benefit plan under this subsection shall clearly disclose all the
10 covered benefits to the small employer in a brochure filed with the
11 commissioner.
12 (b) A health benefit plan offered under this subsection shall
13 provide coverage for hospital expenses and services rendered by a
14 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
15 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350,
16 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and
17 48.46.530.
18 (2) Nothing in this section shall prohibit a health maintenance
19 organization from offering, or a purchaser from seeking, health benefit
20 plans with benefits in excess of the health benefit plan offered under
21 subsection (1) of this section. All forms, policies, and contracts
22 shall be submitted for approval to the commissioner, and the rates of
23 any plan offered under this section shall be reasonable in relation to
24 the benefits thereto.
25 (3) Premium rates for health benefit plans for small employers as
26 defined in this section shall be subject to the following provisions:
27 (a) The health maintenance organization shall develop its rates
28 based on an adjusted community rate and may only vary the adjusted
29 community rate for:
30 (i) Geographic area;
31 (ii) Family size;
32 (iii) Age; and
33 (iv) Wellness activities.
34 (b) The adjustment for age in (a)(iii) of this subsection may not
35 use age brackets smaller than five-year increments, which shall begin
36 with age twenty and end with age sixty-five. Employees under the age
37 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).

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

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

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

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

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

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

(g) On the census date, as defined in RCW 48.46.020, rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, and differences in census date

between new and renewal groups, with the exception of discounts for health improvement programs.

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

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

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

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

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences

in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

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

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

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

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

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

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

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

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

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

(6) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health

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

8 **Sec. 5.** RCW 48.21.045 and 2009 c 131 s 1 are each amended to read
9 as follows:

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

21 (b) A health benefit plan offered under this subsection shall
22 provide coverage for hospital expenses and services rendered by a
23 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
24 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,
25 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,
26 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250,
27 48.21.300, 48.21.310, or 48.21.320.

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

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

1 (a) The insurer shall develop its rates based on an adjusted
2 community rate and may only vary the adjusted community rate for:
3 (i) Geographic area;
4 (ii) Family size;
5 (iii) Age; and
6 (iv) Wellness activities.
7 (b) The adjustment for age in (a)(iii) of this subsection may not
8 use age brackets smaller than five-year increments, which shall begin
9 with age twenty and end with age sixty-five. Employees under the age
10 of twenty shall be treated as those age twenty.
11 (c) The insurer shall be permitted to develop separate rates for
12 individuals age sixty-five or older for coverage for which medicare is
13 the primary payer and coverage for which medicare is not the primary
14 payer. Both rates shall be subject to the requirements of this
15 subsection (3).
16 (d) The permitted rates for any age group shall be no more than
17 four hundred twenty-five percent of the lowest rate for all age groups
18 on January 1, 1996, four hundred percent on January 1, 1997, and three
19 hundred seventy-five percent on January 1, 2000, and thereafter.
20 (e) A discount for wellness activities shall be permitted to
21 reflect actuarially justified differences in utilization or cost
22 attributed to such programs. Up to a twenty percent variance may be
23 allowed for small employers that develop and implement a wellness
24 program or activities that directly improve employee wellness.
25 Employers shall document program activities with the carrier and may,
26 after three years of implementation, request a reduction in premiums
27 based on improved employee health and wellness. While carriers may
28 review the employer's claim history when making a determination
29 regarding whether the employer's wellness program has improved employee
30 health, the carrier may not use maternity or prevention services claims
31 to deny the employer's request. Carriers may consider issues such as
32 improved productivity or a reduction in absenteeism due to illness if
33 submitted by the employer for consideration. Interested employers may
34 also work with the carrier to develop a wellness program and a means to
35 track improved employee health.
36 (f) The rate charged for a health benefit plan offered under this
37 section may not be adjusted more frequently than annually except that
38 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) On the census date, as defined in RCW 48.21.047, rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, and differences in census date between new and renewal groups, with the exception of discounts for health improvement programs.

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

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

detailed actuarial justification for any denial within thirty days of the denial.

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

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

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

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

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

(5)(a) Except as provided in this subsection and subsection (3)(g) of 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) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

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

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

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

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

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

<u>(4) For purposes of this section, "census date" has the same meaning as defined in RCW 48.44.010.</u>

<u>NEW SECTION.</u> **Sec. 7.** This act applies to policies issued on or after January 1, 2011.

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