
HOUSE BILL 1870

State of Washington

66th Legislature

2019 Regular Session

By Representatives Davis, Cody, Ryu, Jinkins, Dolan, Senn, Bergquist, Peterson, Thai, Valdez, Morgan, Robinson, Goodman, Kilduff, Fey, Pollet, Appleton, Orwall, Mead, Kirby, Kloba, Gregerson, Fitzgibbon, Stanford, and Tharinger

Read first time 02/04/19. Referred to Committee on Health Care & Wellness.

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

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

9 **PART I**

10 **DEFINITIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 (e) Disability income;

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

15 (g) Workers' compensation coverage;

16 (h) Accident only coverage;

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

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

22 (k) Dental only and vision only coverage;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (a) Ambulatory patient services;

32 (b) Emergency services;

33 (c) Hospitalization;

34 (d) Maternity and newborn care;

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

37 (f) Prescription drugs;

38 (g) Rehabilitative and habilitative services;

39 (h) Laboratory services;

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

- 3 (i) Geographic area;
- 4 (ii) Family size;
- 5 (iii) Age;
- 6 (iv) Tenure discounts; and
- 7 (v) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (i) Changes to the family composition;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 38 (i) Changes to the family composition;

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

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

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

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

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

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

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

24 **Sec. 8.** RCW 48.46.066 and 2010 c 292 s 6 are each amended to
25 read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36 (i) Adjusted community rates established under this section shall
37 pool the medical experience of all groups purchasing coverage,
38 including the small group participants in the health insurance
39 partnership established in RCW 70.47A.030. However, annual rate
40 adjustments for each small group health benefit plan may vary by up

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 **PART III**

33 **GUARANTEED ISSUE AND ELIGIBILITY**

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

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

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

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

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

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

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

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

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

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

8 (a) Health status;

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

11 (c) Claims experience;

12 (d) Receipt of health care;

13 (e) Medical history;

14 (f) Genetic information;

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

17 (h) Disability; or

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

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

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

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

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

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

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

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

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

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

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

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

11 (a) Terms of renewability;

12 (b) Nonduplication of coverage;

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

14 (d) Definitions of terms.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 **PART IV**

12 **PROHIBITING UNFAIR RESCISSIONS**

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

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

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

27 **PART V**

28 **ESSENTIAL HEALTH BENEFITS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (a) For self-only coverage:

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

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

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

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

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

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

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

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

5 **PART VII**

6 **OPEN ENROLLMENT PERIODS**

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

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

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

19 **PART VIII**

20 **LIFETIME LIMITS**

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

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

26 **PART IX**

27 **MEDICAL LOSS RATIOS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 **PART X**

21 **EXPLANATION OF COVERAGE**

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

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

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

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

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

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

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

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

11 (A) The essential health benefits; and

12 (B) Other benefits identified by the commissioner;

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

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

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

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

21 (vii) A statement of whether the plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

37 **PART XI**

38 **WAITING PERIODS FOR GROUP COVERAGE**

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

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

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

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