

2 **ESHB 1046** - S AMD - 386

3 By Senators Quigley, Deccio, Owen and Moyer

4 ADOPTED AS AMENDED 4/14/95

5 Strike everything after the enacting clause and insert the  
6 following:

7 "NEW SECTION. **Sec. 1.** A new section is added to chapter 70.47 RCW  
8 to read as follows:

9 BASIC HEALTH PLAN--EXPANDED ENROLLMENT. (1) The legislature finds  
10 that the basic health plan has been an effective program in providing  
11 health coverage for uninsured residents. Further, since 1993,  
12 substantial amounts of public funds have been allocated for subsidized  
13 basic health plan enrollment.

14 (2) It is the intent of the legislature that the basic health plan  
15 enrollment be expanded expeditiously, consistent with funds available  
16 in the health services account, with the goal of two hundred thousand  
17 adult subsidized basic health plan enrollees and one hundred thirty  
18 thousand children covered through expanded medical assistance services  
19 by June 30, 1997, with the priority of providing needed health services  
20 to children in conjunction with other public programs.

21 (3) Effective January 1, 1996, basic health plan enrollees whose  
22 income is less than one hundred twenty-five percent of the federal  
23 poverty level shall pay at least a ten-dollar premium share.

24 (4) No later than July 1, 1996, the administrator shall implement  
25 procedures whereby hospitals licensed under chapters 70.41 and 71.12  
26 RCW, health carrier, rural health care facilities regulated under  
27 chapter 70.175 RCW, and community and migrant health centers funded  
28 under RCW 41.05.220, may expeditiously assist patients and their  
29 families in applying for basic health plan or medical assistance  
30 coverage, and in submitting such applications directly to the health  
31 care authority or the department of social and health services. The  
32 health care authority and the department of social and health services  
33 shall make every effort to simplify and expedite the application and  
34 enrollment process.

35 (5) No later than July 1, 1996, the administrator shall implement  
36 procedures whereby health insurance agents and brokers, licensed under

1 chapter 48.17 RCW, may expeditiously assist patients and their families  
2 in applying for basic health plan or medical assistance coverage, and  
3 in submitting such applications directly to the health care authority  
4 or the department of social and health services. Brokers and agents  
5 shall be entitled to receive a commission for each individual sale of  
6 the basic health plan to anyone not at anytime previously signed up and  
7 a commission for each group sale of the basic health plan. No  
8 commission shall be provided upon a renewal. Commissions shall be  
9 determined based on the estimated annual cost of the basic health plan,  
10 however, commissions shall not result in a reduction in the premium  
11 amount paid to health carriers. For purposes of this section "health  
12 carrier" is as defined in section 4 of this act. The health care  
13 authority and the department of social and health services shall make  
14 every effort to simplify and expedite the application and enrollment  
15 process.

16 NEW SECTION. **Sec. 2.** HEALTH CARE SAVINGS ACCOUNTS. (1) This  
17 chapter shall be known as the health care savings account act.

18 (2) The legislature recognizes that the costs of health care are  
19 increasing rapidly and most individuals are removed from participating  
20 in the purchase of their health care.

21 As a result, it becomes critical to encourage and support solutions  
22 to alleviate the demand for diminishing state resources. In response  
23 to these increasing costs in health care spending, the legislature  
24 intends to clarify that health care savings accounts may be offered as  
25 health benefit options to all residents as incentives to reduce  
26 unnecessary health services utilization, administration, and paperwork,  
27 and to encourage individuals to be in charge of and participate  
28 directly in their use of service and health care spending. To  
29 alleviate the possible impoverishment of residents requiring long-term  
30 care, health care savings accounts may promote savings for long-term  
31 care and provide incentives for individuals to protect themselves from  
32 financial hardship due to a long-term health care need.

33 (3) Health care savings accounts are authorized in Washington state  
34 as options to employers and residents.

35 NEW SECTION. **Sec. 3.** HEALTH CARE SAVINGS ACCOUNTS--REQUEST FOR  
36 TAX EXEMPTION. The governor and responsible agencies shall:

1 (1) Request that the United States congress amend the internal  
2 revenue code to treat premiums and contributions to health benefits  
3 plans, such as health care savings account programs, basic health  
4 plans, conventional and standard health plans offered through a health  
5 carrier, by employers, self-employed persons, and individuals, as fully  
6 excluded employer expenses and deductible from individual adjusted  
7 gross income for federal tax purposes.

8 (2) Request that the United States congress amend the internal  
9 revenue code to exempt from federal income tax interest that accrues in  
10 health care savings accounts until such money is withdrawn for  
11 expenditures other than eligible health expenses as defined in law.

12 (3) If all federal statute or regulatory waivers necessary to fully  
13 implement this chapter have not been obtained by the effective date of  
14 this section, this chapter shall remain in effect.

15 NEW SECTION. **Sec. 4.** DEFINITIONS. Unless otherwise specifically  
16 provided, the definitions in this section apply throughout this  
17 chapter.

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

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

26 (3) "Eligible employee" means an employee who works on a full-time  
27 basis with a normal work week of thirty or more hours. The term  
28 includes a self-employed individual, including a sole proprietor, a  
29 partner of a partnership, and may include an independent contractor, if  
30 the self-employed individual, sole proprietor, partner, or independent  
31 contractor is included as an employee under a health benefit plan of a  
32 small employer, but does not work less than thirty hours per week and  
33 derives at least seventy-five percent of his or her income from a trade  
34 or business through which he or she has attempted to earn taxable  
35 income and for which he or she has filed the appropriate internal  
36 revenue service form. Persons covered under a health benefit plan  
37 pursuant to the consolidated omnibus budget reconciliation act of 1986

1 shall not be considered eligible employees for purposes of minimum  
2 participation requirements of this act.

3 (4) "Enrollee point-of-service cost-sharing" means amounts paid to  
4 health carriers directly providing services, health care providers, or  
5 health care facilities by enrollees and may include copayments,  
6 coinsurance, or deductibles.

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

20 (6) "Health care provider" or "provider" means:

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

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

26 (7) "Health care service" means that service offered or provided by  
27 health care facilities and health care providers relating to the  
28 prevention, cure, or treatment of illness, injury, or disease.

29 (8) "Health carrier" or "carrier" means a disability insurer  
30 regulated under chapter 48.20 or 48.21 RCW, a health care service  
31 contractor as defined in RCW 48.44.010, or a health maintenance  
32 organization as defined in RCW 48.46.020.

33 (9) "Health plan" or "health benefit plan" means any policy,  
34 contract, or agreement offered by a health carrier to provide, arrange,  
35 reimburse, or pay for health care service except the following:

36 (a) Long-term care insurance governed by chapter 48.84 RCW;

37 (b) Medicare supplemental health insurance governed by chapter  
38 48.66 RCW;

1 (c) Limited health care service offered by limited health care  
2 service contractors in accordance with RCW 48.44.035;

3 (d) Disability income;

4 (e) Coverage incidental to a property/casualty liability insurance  
5 policy such as automobile personal injury protection coverage and  
6 homeowner guest medical;

7 (f) Workers' compensation coverage;

8 (g) Accident only coverage;

9 (h) Specified disease and hospital confinement indemnity when  
10 marketed solely as a supplement to a health plan;

11 (i) Employer-sponsored self-funded health plans; and

12 (j) Dental only and vision only coverage.

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

17 (11) "Preexisting condition" means any medical condition, illness,  
18 or injury that existed any time prior to the effective date of  
19 coverage.

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

27 (13) "Small employer" means any person, firm, corporation,  
28 partnership, association, political subdivision except school  
29 districts, or self-employed individual that is actively engaged in  
30 business that, on at least fifty percent of its working days during the  
31 preceding calendar quarter, employed no more than fifty eligible  
32 employees, with a normal work week of thirty or more hours, the  
33 majority of whom were employed within this state, and is not formed  
34 primarily for purposes of buying health insurance and in which a bona  
35 fide employer-employee relationship exists. In determining the number  
36 of eligible employees, companies that are affiliated companies, or that  
37 are eligible to file a combined tax return for purposes of taxation by  
38 this state, shall be considered an employer. Subsequent to the  
39 issuance of a health plan to a small employer and for the purpose of

1 determining eligibility, the size of a small employer shall be  
2 determined annually. Except as otherwise specifically provided, a  
3 small employer shall continue to be considered a small employer until  
4 the plan anniversary following the date the small employer no longer  
5 meets the requirements of this definition. The term "small employer"  
6 includes a self-employed individual or sole proprietor. The term  
7 "small employer" also includes a self-employed individual or sole  
8 proprietor who derives at least seventy-five percent of his or her  
9 income from a trade or business through which the individual or sole  
10 proprietor has attempted to earn taxable income and for which he or she  
11 has filed the appropriate Internal Revenue Service form 1040, Schedule  
12 C or F, for the previous taxable year.

13 (14) "Wellness activity" means an explicit program of an activity  
14 consistent with department of health guidelines, such as, smoking  
15 cessation, injury and accident prevention, reduction of alcohol misuse,  
16 appropriate weight reduction, exercise, automobile and motorcycle  
17 safety, blood cholesterol reduction, and nutrition education for the  
18 purpose of improving enrollee health status and reducing health service  
19 costs.

20 (15) "Basic health plan" means the plan described under chapter  
21 70.47 RCW, as revised from time to time.

22 NEW SECTION. **Sec. 5.** INSURANCE REFORM--PORTABILITY. (1) Every  
23 health carrier shall waive any preexisting condition exclusion or  
24 limitation for persons or groups who had similar health coverage under  
25 a different health plan at any time during the three-month period  
26 immediately preceding the date of application for the new health plan  
27 if such person was continuously covered under the immediately preceding  
28 health plan. If the person was continuously covered for at least three  
29 months under the immediately preceding health plan, the carrier may not  
30 impose a waiting period for coverage of preexisting conditions. If the  
31 person was continuously covered for less than three months under the  
32 immediately preceding health plan, the carrier must credit any waiting  
33 period under the immediately preceding health plan toward the new  
34 health plan. For the purposes of this subsection, a preceding health  
35 plan includes an employer provided self-funded health plan.

36 (2) Subject to the provisions of subsection (1) of this section,  
37 nothing contained in this section requires a health carrier to amend a  
38 health plan to provide new benefits in its existing health plans. In

1 addition, nothing in this section requires a carrier to waive benefit  
2 limitations not related to an individual or group's preexisting  
3 conditions or health history.

4 NEW SECTION. **Sec. 6.** INSURANCE REFORM--PREEXISTING CONDITIONS.

5 (1) No carrier may reject an individual for health plan coverage based  
6 upon preexisting conditions of the individual and no carrier may deny,  
7 exclude, or otherwise limit coverage for an individual's preexisting  
8 health conditions; except that a carrier may impose a three-month  
9 benefit waiting period for preexisting conditions for which medical  
10 advice was given, or for which a health care provider recommended or  
11 provided treatment within three months before the effective date of  
12 coverage.

13 (2) No carrier may avoid the requirements of this section through  
14 the creation of a new rate classification or the modification of an  
15 existing rate classification. A new or changed rate classification  
16 will be deemed an attempt to avoid the provisions of this section if  
17 the new or changed classification would substantially discourage  
18 applications for coverage from individuals or groups who are higher  
19 than average health risks. These provisions apply only to individuals  
20 who are Washington residents.

21 NEW SECTION. **Sec. 7.** INSURANCE REFORM--GUARANTEED ISSUE. (1) All

22 health carriers shall accept for enrollment any state resident within  
23 the carrier's service area and provide or assure the provision of all  
24 covered services regardless of age, sex, family structure, ethnicity,  
25 race, health condition, geographic location, employment status,  
26 socioeconomic status, other condition or situation, or the provisions  
27 of RCW 49.60.174(2). The insurance commissioner may grant a temporary  
28 exemption from this subsection, if, upon application by a health  
29 carrier the commissioner finds that the clinical, financial, or  
30 administrative capacity to serve existing enrollees will be impaired if  
31 a health carrier is required to continue enrollment of additional  
32 eligible individuals.

33 (2) Except as provided in subsection (5) of this section, all  
34 health plans shall contain or incorporate by endorsement a guarantee of  
35 the continuity of coverage of the plan. For the purposes of this  
36 section, a plan is "renewed" when it is continued beyond the earliest  
37 date upon which, at the carrier's sole option, the plan could have been

1 terminated for other than nonpayment of premium. In the case of group  
2 plans, the carrier may consider the group's anniversary date as the  
3 renewal date for purposes of complying with the provisions of this  
4 section.

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

8 (a) Nonpayment of premium;

9 (b) Violation of published policies of the carrier approved by the  
10 insurance commissioner;

11 (c) Covered persons entitled to become eligible for medicare  
12 benefits by reason of age who fail to apply for a medicare supplement  
13 plan or medicare cost, risk, or other plan offered by the carrier  
14 pursuant to federal laws and regulations;

15 (d) Covered persons who fail to pay any deductible or copayment  
16 amount owed to the carrier and not the provider of health care  
17 services;

18 (e) Covered persons committing fraudulent acts as to the carrier;

19 (f) Covered persons who materially breach the health plan; or

20 (g) Change or implementation of federal or state laws that no  
21 longer permit the continued offering of such coverage.

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

24 (a) A carrier has zero enrollment on a product; or

25 (b) A carrier replaces a product and the replacement product is  
26 provided to all covered persons within that class or line of business,  
27 includes all of the services covered under the replaced product, and  
28 does not significantly limit access to the kind of services covered  
29 under the replaced product. The health plan may also allow  
30 unrestricted conversion to a fully comparable product; or

31 (c) A carrier is withdrawing from a service area or from a segment  
32 of its service area because the carrier has demonstrated to the  
33 insurance commissioner that the carrier's clinical, financial, or  
34 administrative capacity to serve enrollees would be exceeded.

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

1        NEW SECTION.    **Sec. 8.**    A new section is added to chapter 48.43 RCW  
2 to read as follows:

3        Every health plan delivered, issued for delivery, or renewed by a  
4 health carrier on and after January 1, 1996, shall:

5        (1) Permit every category of health care provider to provide health  
6 services or care for conditions included in the basic health plan  
7 services to the extent that:

8        (a) The provision of such health services or care is within the  
9 health care providers' permitted scope of practice; and

10        (b) The providers agree to abide by standards related to:

11        (i) Provision, utilization review, and cost containment of health  
12 services;

13        (ii) Management and administrative procedures; and

14        (iii) Provision of cost-effective and clinically efficacious health  
15 services.

16        (2) Annually report the names and addresses of all officers,  
17 directors, or trustees of the health carrier during the preceding year,  
18 and the amount of wages, expense reimbursements, or other payments to  
19 such individuals.

20        NEW SECTION.    **Sec. 9.**    WASHINGTON HEALTH CARE POLICY BOARD.    (1)  
21 There is hereby created the Washington health care policy board. The  
22 board shall consist of: (a) Five members appointed by the governor;  
23 (b) two members of the senate appointed by the president of the senate,  
24 one of whom shall be a member of the minority party; and (c) two  
25 members of the house of representatives appointed by the speaker of the  
26 house of representatives, one of whom shall be a member of the minority  
27 party. One member of the board shall be designated by the governor as  
28 chair and shall serve at the pleasure of the governor. All legislative  
29 members shall be appointed before the close of each regular or special  
30 session during an odd-numbered year.

31        (2) Of the members appointed by the governor, two shall be  
32 appointed to two-year terms and two shall be appointed to three-year  
33 terms. Thereafter, members shall be appointed to three-year terms.  
34 The chair shall serve at the pleasure of the governor. Vacancies shall  
35 be filled by appointment for the remainder of the unexpired term of the  
36 position being vacated. A majority of the voting members shall  
37 constitute a quorum.

1 (3) Members of the board appointed by the governor shall occupy  
2 their positions on a full-time basis and are exempt from the provisions  
3 of chapter 41.06 RCW. They shall be paid a salary to be fixed by the  
4 governor in accordance with RCW 43.03.040.

5 NEW SECTION. **Sec. 10.** CHAIR--POWERS AND DUTIES. The chair shall  
6 be the chief administrative officer and the appointing authority of the  
7 board. The chair shall have the authority to employ personnel of the  
8 board in accordance with chapter 41.06 RCW and prescribe their duties.  
9 The chair may employ up to eight personnel exempt from the provisions  
10 of chapter 41.06 RCW. The chair shall also have the following powers  
11 and duties:

- 12 (1) Enter into contracts on behalf of the board;  
13 (2) Accept and expend donations, grants, and other funds received  
14 by the board;  
15 (3) Appoint advisory committees and undertake studies, research,  
16 and analysis necessary to support activities of the board.

17 NEW SECTION. **Sec. 11.** BOARD--POWERS AND DUTIES. The board shall  
18 have the following powers and duties:

- 19 (1) Periodically make recommendations to the appropriate committees  
20 of the legislature and the governor on issues including, but not  
21 limited to the following:  
22 (a) The scope, financing, and delivery of health care benefit plans  
23 including access for both the insured and uninsured population;  
24 (b) Long-term care services including the finance and delivery of  
25 such services in conjunction with the basic health plan by 1999;  
26 (c) The use of health care savings accounts including their impact  
27 on the health of participants and the cost of health insurance;  
28 (d) Rural health care needs;  
29 (e) Whether Washington is experiencing an increase in immigration  
30 as a result of health insurance reforms and the availability of  
31 subsidized and unsubsidized health care benefits;  
32 (f) The status of medical education and make recommendations  
33 regarding steps possible to encourage adequate availability of health  
34 care professionals to meet the needs of the state's populations with  
35 particular attention to rural areas;  
36 (g) The implementation of community rating and its impacts on the  
37 marketplace including costs and access;

1 (h) The status of quality improvement programs in both the public  
2 and private sectors;

3 (i) Models for billing and claims processing forms, ensuring that  
4 these procedures minimize administrative burdens on health care  
5 providers, facilities, carriers, and consumers. These standards shall  
6 also apply to state-purchased health services where appropriate;

7 (j) Guidelines to health carriers for utilization management and  
8 review, provider selection and termination policies, and coordination  
9 of benefits and premiums; and

10 (k) Study the feasibility of including long-term care services in  
11 a medicare supplemental insurance policy offered according to RCW  
12 41.05.197;

13 (2) Review rules prepared by the insurance commissioner, health  
14 care authority, department of social and health services, department of  
15 labor and industries, and department of health, and make  
16 recommendations where appropriate to facilitate consistency with the  
17 goals of health reform;

18 (3) Make recommendations on a system for managing health care  
19 services to children with special needs and report to the governor and  
20 the legislature on their findings by January 1, 1997;

21 (4) Conduct a comparative analysis of individual and group  
22 insurance markets addressing: Relative costs; utilization rates;  
23 adverse selection; and specific impacts upon small businesses and  
24 individuals. The analysis shall address, also, the necessity and  
25 feasibility of establishing explicit related policies, to include, but  
26 not be limited to, establishing the maximum allowable individual  
27 premium rate as a percentage of the small group premium rate. The  
28 board shall submit an interim report on its findings to the governor  
29 and appropriate committees of the legislature by December 15, 1995, and  
30 a final report on December 15, 1996;

31 (5) Develop sample enrollee satisfaction surveys that may be used  
32 by health carriers.

33 NEW SECTION. **Sec. 12.** STUDY. In January 1999 the legislative  
34 budget committee shall commence a study of the necessity of the  
35 existence of the board and report its recommendations to the  
36 appropriate committees of the legislature by December 1, 1999.

1        NEW SECTION.    **Sec. 13.**    A new section is added to chapter 48.20 RCW  
2 to read as follows:

3        (1)(a)    An insurer offering any health benefit plan to any  
4 individual shall offer and actively market to all individuals a health  
5 benefit plan providing benefits identical to the schedule of covered  
6 health services that are required to be delivered to an individual  
7 enrolled in the basic health plan.    Nothing in this subsection shall  
8 preclude an insurer from offering, or an individual from purchasing,  
9 other health benefit plans that may have more or less comprehensive  
10 benefits than the basic health plan, provided such plans are in  
11 accordance with this chapter.    An insurer offering a health benefit  
12 plan that does not include benefits provided in the basic health plan  
13 shall clearly disclose these differences to the individual in a  
14 brochure approved by the commissioner.

15        (b)    A health benefit plan shall provide coverage for hospital  
16 expenses and services rendered by a physician licensed under chapter  
17 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
18 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411,  
19 48.20.412, 48.20.416, and 48.20.420 if the health benefit plan is the  
20 mandatory offering under (a) of this subsection that provides benefits  
21 identical to the basic health plan, to the extent these requirements  
22 differ from the basic health plan.

23        (2)    Premiums for health benefit plans for individuals shall be  
24 calculated using the adjusted community rating method that spreads  
25 financial risk across the carrier's entire individual product  
26 population.    All such rates shall conform to the following:

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

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

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

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

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

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

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

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

13 (i) Changes to the family composition;

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

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

18 (g) For the purposes of this section, a health benefit plan that  
19 contains a restricted network provision shall not be considered similar  
20 coverage to a health benefit plan that does not contain such a  
21 provision, provided that the restrictions of benefits to network  
22 providers result in substantial differences in claims costs. This  
23 subsection does not restrict or enhance the portability of benefits as  
24 provided in section 5 of this act.

25 (3) Adjusted community rates established under this section shall  
26 pool the medical experience of all individuals purchasing coverage, and  
27 shall not be required to be pooled with the medical experience of  
28 health benefit plans offered to small employers under RCW 48.21.045.

29 (4) As used in this section, "health benefit plan," "basic health  
30 plan," "adjusted community rate," and "wellness activities" mean the  
31 same as defined in section 4 of this act.

32 **Sec. 14.** RCW 48.21.045 and 1990 c 187 s 2 are each amended to read  
33 as follows:

34 ~~((A basic group disability insurance policy may be offered to  
35 employers of fewer than twenty-five employees. Such a basic group  
36 disability insurance policy))~~ (1)(a) An insurer offering any health  
37 benefit plan to a small employer shall offer and actively market to the  
38 small employer a health benefit plan providing benefits identical to

1 the schedule of covered health services that are required to be  
2 delivered to an individual enrolled in the basic health plan. Nothing  
3 in this subsection shall preclude an insurer from offering, or a small  
4 employer from purchasing, other health benefit plans that may have more  
5 or less comprehensive benefits than the basic health plan, provided  
6 such plans are in accordance with this chapter. An insurer offering a  
7 health benefit plan that does not include benefits in the basic health  
8 plan shall clearly disclose these differences to the small employer in  
9 a brochure approved by the commissioner.

10 (b) A health benefit plan shall provide coverage for hospital  
11 expenses and services rendered by a physician licensed under chapter  
12 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
13 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146,  
14 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225,  
15 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300,  
16 48.21.310, or 48.21.320 if: (i) The health benefit plan is the  
17 mandatory offering under (a) of this subsection that provides benefits  
18 identical to the basic health plan, to the extent these requirements  
19 differ from the basic health plan; or (ii) the health benefit plan is  
20 offered to employers with not more than twenty-five employees.

21 (2) Nothing in this section shall prohibit an insurer from  
22 offering, or a purchaser from seeking, benefits in excess of the basic  
23 ((coverage authorized herein)) health plan services. All forms,  
24 policies, and contracts shall be submitted for approval to the  
25 commissioner, and the rates of any plan offered under this section  
26 shall be reasonable in relation to the benefits thereto.

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

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

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

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

1       (c) The insurer shall be permitted to develop separate rates for  
2 individuals age sixty-five or older for coverage for which medicare is  
3 the primary payer and coverage for which medicare is not the primary  
4 payer. Both rates shall be subject to the requirements of this  
5 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 groups  
8 on January 1, 1996, four hundred percent on January 1, 1997, and three  
9 hundred seventy-five percent on January 1, 2000, and thereafter.

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

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) Rating factors shall produce premiums for identical groups that  
23 differ only by the amounts attributable to plan design, with the  
24 exception of discounts for health improvement programs.

25       (h) For the purposes of this section, a health benefit plan that  
26 contains a restricted network provision shall not be considered similar  
27 coverage to a health benefit plan that does not contain such a  
28 provision, provided that the restrictions of benefits to network  
29 providers result in substantial differences in claims costs. This  
30 subsection does not restrict or enhance the portability of benefits as  
31 provided in section 5 of this act.

32       (i) Adjusted community rates established under this section shall  
33 pool the medical experience of all small groups purchasing coverage.

34       (4) The ((policy)) health benefit plans authorized by this section  
35 that are lower than the required offering shall not supplant or  
36 supersede any existing policy for the benefit of employees in this  
37 state. Nothing in this section shall restrict the right of employees  
38 to collectively bargain for insurance providing benefits in excess of  
39 those provided herein.

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

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

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

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

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

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

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

27       (7) As used in this section, "health benefit plan," "small  
28 employer," "basic health plan," "adjusted community rate," and  
29 "wellness activities" mean the same as defined in section 4 of this  
30 act.

31       **NEW SECTION. Sec. 15.** A new section is added to chapter 48.44 RCW  
32 to read as follows:

33       (1)(a) A health care service contractor offering any health benefit  
34 plan to any individual shall offer and actively market to all  
35 individuals a health benefit plan providing benefits identical to the  
36 schedule of covered health services that are required to be delivered  
37 to an individual enrolled in the basic health plan. Nothing in this  
38 subsection shall preclude a contractor from offering, or an individual

1 from purchasing, other health benefit plans that may have more or less  
2 comprehensive benefits than the basic health plan, provided such plans  
3 are in accordance with this chapter. A contractor offering a health  
4 benefit plan that does not include benefits provided in the basic  
5 health plan shall clearly disclose these differences to the individual  
6 in a brochure approved by the commissioner.

7 (b) A health benefit plan shall provide coverage for hospital  
8 expenses and services rendered by a physician licensed under chapter  
9 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
10 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310,  
11 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344,  
12 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if the health  
13 benefit plan is the mandatory offering under (a) of this subsection  
14 that provides benefits identical to the basic health plan, to the  
15 extent these requirements differ from the basic health plan.

16 (2) Premium rates for health benefit plans for individuals shall be  
17 subject to the following provisions:

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

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

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

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

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

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

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

7 (i) Changes to the family composition;

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

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

12 (g) For the purposes of this section, a health benefit plan that  
13 contains a restricted network provision shall not be considered similar  
14 coverage to a health benefit plan that does not contain such a  
15 provision, provided that the restrictions of benefits to network  
16 providers result in substantial differences in claims costs. This  
17 subsection does not restrict or enhance the portability of benefits as  
18 provided in section 5 of this act.

19 (3) Adjusted community rates established under this section shall  
20 pool the medical experience of all individuals purchasing coverage, and  
21 shall not be required to be pooled with the medical experience of  
22 health benefit plans offered to small employers under RCW 48.44.023.

23 (4) As used in this section and RCW 48.44.023 "health benefit  
24 plan," "small employer," "basic health plan," "adjusted community  
25 rates," and "wellness activities" mean the same as defined in section  
26 4 of this act.

27 **Sec. 16.** RCW 48.44.023 and 1990 c 187 s 3 are each amended to read  
28 as follows:

29 ~~((A basic health care service contract may be offered to employers  
30 of fewer than twenty five employees. Such a basic health care service  
31 contract))~~ (1)(a) A health care services contractor offering any health  
32 benefit plan to a small employer shall offer and actively market to the  
33 small employer a health benefit plan providing benefits identical to  
34 the schedule of covered health services that are required to be  
35 delivered to an individual enrolled in the basic health plan. Nothing  
36 in this subsection shall preclude a contractor from offering, or a  
37 small employer from purchasing, other health benefit plans that may  
38 have more or less comprehensive benefits than the basic health plan,

1 provided such plans are in accordance with this chapter. A contractor  
2 offering a health benefit plan that does not include benefits in the  
3 basic health plan shall clearly disclose these differences to the small  
4 employer in a brochure approved by the commissioner.

5 (b) A health benefit plan shall provide coverage for hospital  
6 expenses and services rendered by a physician licensed under chapter  
7 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
8 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310,  
9 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344,  
10 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if (i) The  
11 health benefit plan is the mandatory offering under (a) of this  
12 subsection that provides benefits identical to the basic health plan,  
13 to the extent these requirements differ from the basic health plan; or  
14 (ii) the health benefit plan is offered to employers with not more than  
15 twenty-five employees.

16 (2) Nothing in this section shall prohibit ((an insurer)) a health  
17 care service contractor from offering, or a purchaser from seeking,  
18 benefits in excess of the basic ((coverage authorized herein)) health  
19 plan services. All forms, policies, and contracts shall be submitted  
20 for approval to the commissioner, and the rates of any plan offered  
21 under this section shall be reasonable in relation to the benefits  
22 thereto.

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

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

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

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

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

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

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

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

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

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

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

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

17 (g) Rating factors shall produce premiums for identical groups that  
18 differ only by the amounts attributable to plan design, with the  
19 exception of discounts for health improvement programs.

20 (h) For the purposes of this section, a health benefit plan that  
21 contains a restricted network provision shall not be considered similar  
22 coverage to a health benefit plan that does not contain such a  
23 provision, provided that the restrictions of benefits to network  
24 providers result in substantial differences in claims costs. This  
25 subsection does not restrict or enhance the portability of benefits as  
26 provided in section 5 of this act.

27 (i) Adjusted community rates established under this section shall  
28 pool the medical experience of all groups purchasing coverage.

29 (4) The ((policy)) health benefit plans authorized by this section  
30 that are lower than the required offering shall not supplant or  
31 supersede any existing policy for the benefit of employees in this  
32 state. 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, requirements used by  
36 a contractor in determining whether to provide coverage to a small  
37 employer shall be applied uniformly among all small employers applying  
38 for coverage or receiving coverage from the carrier.

1       (b) A contractor shall not require a minimum participation level  
2 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 groups  
6 with more than three employees.

7       (c) In applying minimum participation requirements with respect to  
8 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 contractor may not increase any requirement for minimum  
12 employee participation or modify any requirement for minimum employer  
13 contribution applicable to a small employer at any time after the small  
14 employer has been accepted for coverage.

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

23       NEW SECTION. Sec. 17. A new section is added to chapter 48.46 RCW  
24 to read as follows:

25       (1)(a) A health maintenance organization offering any health  
26 benefit plan to any individual shall offer and actively market to all  
27 individuals a health benefit plan providing benefits identical to the  
28 schedule of covered health services that are required to be delivered  
29 to an individual enrolled in the basic health plan. Nothing in this  
30 subsection shall preclude a health maintenance organization from  
31 offering, or an individual from purchasing, other health benefit plans  
32 that may have more or less comprehensive benefits than the basic health  
33 plan, provided such plans are in accordance with this chapter. A  
34 health maintenance organization offering a health benefit plan that  
35 does not include benefits provided in the basic health plan shall  
36 clearly disclose these differences to the individual in a brochure  
37 approved by the commissioner.

1 (b) A health benefit plan shall provide coverage for hospital  
2 expenses and services rendered by a physician licensed under chapter  
3 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
4 48.46.275, 48.26.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355,  
5 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if  
6 the health benefit plan is the mandatory offering under (a) of this  
7 subsection that provides benefits identical to the basic health plan,  
8 to the extent these requirements differ from the basic health plan.

9 (2) Premium rates for health benefit plans for individuals shall be  
10 subject to the following provisions:

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

- 14 (i) Geographic area;
- 15 (ii) Family size;
- 16 (iii) Age; and
- 17 (iv) 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 age  
21 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 which  
25 medicare is not the primary payer. Both rates shall be subject to the  
26 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 groups  
29 on January 1, 1996, four hundred percent on January 1, 1997, and three  
30 hundred seventy-five percent on January 1, 2000, and thereafter.

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

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

- 37 (i) Changes to the family composition;
- 38 (ii) Changes to the health benefit plan requested by the  
39 individual; or

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

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

10 (3) Adjusted community rates established under this section shall  
11 pool the medical experience of all individuals purchasing coverage, and  
12 shall not be required to be pooled with the medical experience of  
13 health benefit plans offered to small employers under RCW 48.46.066.

14 (4) As used in this section and RCW 48.46.066, "health benefit  
15 plan," "basic health plan," "adjusted community rate," "small  
16 employer," and "wellness activities" mean the same as defined in  
17 section 4 of this act.

18 **Sec. 18.** RCW 48.46.066 and 1990 c 187 s 4 are each amended to read  
19 as follows:

20 ~~((A basic health maintenance agreement may be offered to employers  
21 of fewer than twenty five employees. Such a basic health maintenance  
22 agreement))~~ (1)(a) A health maintenance organization offering any  
23 health benefit plan to a small employer shall offer and actively market  
24 to the small employer a health benefit plan providing benefits  
25 identical to the schedule of covered health services that are required  
26 to be delivered to an individual enrolled in the basic health plan.  
27 Nothing in this subsection shall preclude a health maintenance  
28 organization from offering, or a small employer from purchasing, other  
29 health benefit plans that may have more or less comprehensive benefits  
30 than the basic health plan, provided such plans are in accordance with  
31 this chapter. A health maintenance organization offering a health  
32 benefit plan that does not include benefits in the basic health plan  
33 shall clearly disclose these differences to the small employer in a  
34 brochure approved by the commissioner.

35 (b) A health benefit plan shall provide coverage for hospital  
36 expenses and services rendered by a physician licensed under chapter  
37 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
38 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355,

1 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530  
2 if: (i) The health benefit plan is the mandatory offering under (a) of  
3 this subsection that provides benefits identical to the basic health  
4 plan, to the extent these requirements differ from the basic health  
5 plan; or (ii) the health benefit plan is offered to employers with not  
6 more than twenty-five employees.

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (g) Rating factors shall produce premiums for identical groups that  
11 differ only by the amounts attributable to plan design, with the  
12 exception of discounts for health improvement programs.

13 (h) For the purposes of this section, a health benefit plan that  
14 contains a restricted network provision shall not be considered similar  
15 coverage to a health benefit plan that does not contain such a  
16 provision, provided that the restrictions of benefits to network  
17 providers result in substantial differences in claims costs. This  
18 subsection does not restrict or enhance the portability of benefits as  
19 provided in section 5 of this act.

20 (i) Adjusted community rates established under this section shall  
21 pool the medical experience of all groups purchasing coverage.

22 (4) The ((policy)) health benefit plans authorized by this section  
23 that are lower than the required offering shall not supplant or  
24 supersede any existing policy for the benefit of employees in this  
25 state. Nothing in this section shall restrict the right of employees  
26 to collectively bargain for insurance providing benefits in excess of  
27 those provided herein.

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

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

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

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

38 (c) In applying minimum participation requirements with respect to  
39 a small employer, a small employer shall not consider employees or

1 dependents who have similar existing coverage in determining whether  
2 the applicable percentage of participation is met.

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

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

17 NEW SECTION. Sec. 19. A new section is added to chapter 43.70 RCW  
18 to read as follows:

19 (1) The identity of a whistleblower who complains, in good faith,  
20 to the department of health about the improper quality of care by a  
21 health care provider, or in a health care facility, as defined in RCW  
22 43.72.010, shall remain confidential. The provisions of RCW 4.24.500  
23 through 4.24.520, providing certain protections to persons who  
24 communicate to government agencies, shall apply to complaints filed  
25 under this section. The identity of the whistleblower shall remain  
26 confidential unless the department determines that the complaint was  
27 not made in good faith. An employee who is a whistleblower, as defined  
28 in this section, and who as a result of being a whistleblower has been  
29 subjected to workplace reprisal or retaliatory action has the remedies  
30 provided under chapter 49.60 RCW.

31 (2)(a) "Improper quality of care" means any practice, procedure,  
32 action, or failure to act that violates any state law or rule of the  
33 applicable state health licensing authority under Title 18 or chapters  
34 70.41, 70.96A, 70.127, 70.175, 71.05, 71.12, and 71.24 RCW, and  
35 enforced by the department of health. Each health disciplinary  
36 authority as defined in RCW 18.130.040 may, with consultation and  
37 interdisciplinary coordination provided by the state department of  
38 health, adopt rules defining accepted standards of practice for their

1 profession that shall further define improper quality of care.  
2 Improper quality of care shall not include good faith personnel actions  
3 related to employee performance or actions taken according to  
4 established terms and conditions of employment.

5 (b) "Reprisal or retaliatory action" means but is not limited to:  
6 Denial of adequate staff to perform duties; frequent staff changes;  
7 frequent and undesirable office changes; refusal to assign meaningful  
8 work; unwarranted and unsubstantiated report of misconduct pursuant to  
9 Title 18 RCW; letters of reprimand or unsatisfactory performance  
10 evaluations; demotion; reduction in pay; denial of promotion;  
11 suspension; dismissal; denial of employment; and a supervisor or  
12 superior encouraging coworkers to behave in a hostile manner toward the  
13 whistleblower.

14 (c) "Whistleblower" means a consumer, employee, or health care  
15 professional who in good faith reports alleged quality of care concerns  
16 to the department of health.

17 (3) Nothing in this section prohibits a health care facility from  
18 making any decision exercising its authority to terminate, suspend, or  
19 discipline an employee who engages in workplace reprisal or retaliatory  
20 action against a whistleblower.

21 (4) The department shall adopt rules to implement procedures for  
22 filing, investigation, and resolution of whistleblower complaints that  
23 are integrated with complaint procedures under Title 18 RCW for health  
24 professionals or health care facilities.

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

27 Each health carrier as defined under section 4 of this act shall  
28 file with the commissioner its procedures for review and adjudication  
29 of complaints initiated by covered persons or health care providers.  
30 Procedures filed under this section shall provide a fair review for  
31 consideration of complaints. Every health carrier shall provide  
32 reasonable means whereby any person aggrieved by actions of the health  
33 carrier may be heard in person or by their authorized representative on  
34 their written request for review. If the health carrier fails to grant  
35 or reject such request within thirty days after it is made, the  
36 complaining person may proceed as if the complaint had been rejected.  
37 A complaint that has been rejected by the health carrier may be  
38 submitted to nonbinding mediation. Mediation shall be conducted

1 pursuant to mediation rules similar to those of the American  
2 arbitration association, the center for public resources, the judicial  
3 arbitration and mediation service, RCW 7.70.100, or any other rules of  
4 mediation agreed to by the parties.

5 NEW SECTION. **Sec. 21.** The health care authority, the office of  
6 financial management, and the department of social and health services  
7 shall together monitor the enrollee level in the basic health plan and  
8 the medicaid caseload of children funded from the health services  
9 account. The office of financial management shall adjust the funding  
10 levels by interagency reimbursement of funds between the basic health  
11 plan and medicaid and adjust the funding levels between the health care  
12 authority and the medical assistance administration of the department  
13 of social and health services to maximize combined enrollment.

14 NEW SECTION. **Sec. 22.** A new section is added to chapter 48.21 RCW  
15 to read as follows:

16 (1) No insurer shall offer any health benefit plan to any small  
17 employer without complying with the provisions of RCW 48.21.045(5).

18 (2) Employers purchasing health plans provided through associations  
19 or through member-governed groups formed specifically for the purpose  
20 of purchasing health care shall not be considered small employers and  
21 such plans shall not be subject to the provisions of RCW 48.21.045(5).

22 (3) For purposes of this section, "health benefit plan," "health  
23 plan," and "small employer" mean the same as defined in section 4 of  
24 this act.

25 NEW SECTION. **Sec. 23.** A new section is added to chapter 48.44 RCW  
26 to read as follows:

27 (1) No health care service contractor shall offer any health  
28 benefit plan to any small employer without complying with the  
29 provisions of RCW 48.44.023(5).

30 (2) Employers purchasing health plans provided through associations  
31 or through member-governed groups formed specifically for the purpose  
32 of purchasing health care shall not be considered small employers and  
33 such plans shall not be subject to the provisions of RCW 48.44.023(5).

34 (3) For purposes of this section, "health benefit plan," "health  
35 plan," and "small employer" mean the same as defined in section 4 of  
36 this act.

1        NEW SECTION.    **Sec. 24.**    A new section is added to chapter 48.46 RCW  
2 to read as follows:

3        (1) No health maintenance organization shall offer any health  
4 benefit plan to any small employer without complying with the  
5 provisions of RCW 48.46.066(5).

6        (2) Employers purchasing health plans provided through associations  
7 or through member-governed groups formed specifically for the purpose  
8 of purchasing health care shall not be considered small employers and  
9 such plans shall not be subject to the provisions of RCW 48.46.066(5).

10       (3) For purposes of this section, "health benefit plan," "health  
11 plan," and "small employer" mean the same as defined in section 4 of  
12 this act.

13       NEW SECTION.    **Sec. 25.**    (1) The legislature recognizes that every  
14 individual possesses a fundamental right to exercise their religious  
15 beliefs and conscience.    The legislature further recognizes that in  
16 developing public policy, conflicting religious and moral beliefs must  
17 be respected.    Therefore, while recognizing the right of conscientious  
18 objection to participating in specific health services, the state shall  
19 also recognize the right of individuals enrolled with plans containing  
20 the basic health plan services to receive the full range of services  
21 covered under the plan.

22       (2)(a) No individual health care provider, religiously sponsored  
23 health carrier, or health care facility may be required by law or  
24 contract in any circumstances to participate in the provision of or  
25 payment for a specific service if they object to so doing for reason of  
26 conscience or religion.    No person may be discriminated against in  
27 employment or professional privileges because of such objection.

28       (b) The provisions of this section are not intended to result in an  
29 enrollee being denied timely access to any service included in the  
30 basic health plan services.    Each health carrier shall:

31       (i) Provide written notice to enrollees, upon enrollment with the  
32 plan, listing services that the carrier refuses to cover for reason of  
33 conscience or religion;

34       (ii) Provide written information describing how an enrollee may  
35 directly access services in an expeditious manner; and

36       (iii) Ensure that enrollees refused services under this section  
37 have prompt access to the information developed pursuant to (b)(ii) of  
38 this subsection.

1 (c) The insurance commissioner shall establish by rule a mechanism  
2 or mechanisms to recognize the right to exercise conscience while  
3 ensuring enrollees timely access to services and to assure prompt  
4 payment to service providers.

5 (3)(a) No individual or organization with a religious or moral  
6 tenet opposed to a specific service may be required to purchase  
7 coverage for that service or services if they object to doing so for  
8 reason of conscience or religion.

9 (b) The provisions of this section shall not result in an enrollee  
10 being denied coverage of, and timely access to, any service or services  
11 excluded from their benefits package as a result of their employer's or  
12 another individual's exercise of the conscience clause in (a) of this  
13 subsection.

14 (c) The insurance commissioner shall define by rule the process  
15 through which health carriers may offer the basic health plan services  
16 to individuals and organizations identified in (a) and (b) of this  
17 subsection in accordance with the provisions of subsection (2)(c) of  
18 this section.

19 (4) Nothing in this section requires a health carrier, health care  
20 facility, or health care provider to provide any health care services  
21 without appropriate payment of premium or fee.

22 NEW SECTION. **Sec. 26.** The department of social and health  
23 services, in consultation with the health care authority, the office of  
24 financial management, and other appropriate state agencies, shall seek  
25 necessary federal waivers and state law changes to the medical  
26 assistance program of the department to achieve greater coordination in  
27 financing, purchasing, and delivering health services to low-income  
28 residents of Washington state in a cost-effective manner, and to expand  
29 access to care for these low-income residents. Such waivers shall  
30 include any waiver needed to require that point-of-service cost-  
31 sharing, based on recipient household income, be applied to medical  
32 assistance recipients. In negotiating the waiver, consideration shall  
33 be given to the degree to which benefits in addition to the minimum  
34 list of services should be offered to medical assistance recipients.

35 NEW SECTION. **Sec. 27.** REPEALERS. The following acts or parts of  
36 acts are each repealed:

37 (1) RCW 18.130.320 and 1993 c 492 s 408;

- 1 (2) RCW 18.130.330 and 1994 c 102 s 1 & 1993 c 492 s 412;
- 2 (3) RCW 43.72.005 and 1993 c 492 s 401;
- 3 (4) RCW 43.72.010 and 1994 c 4 s 1, 1993 c 494 s 1, & 1993 c 492 s
- 4 402;
- 5 (5) RCW 43.72.020 and 1994 c 154 s 311 & 1993 c 492 s 403;
- 6 (6) RCW 43.72.030 and 1993 c 492 s 405;
- 7 (7) RCW 43.72.040 and 1994 c 4 s 3, 1993 c 494 s 2, & 1993 c 492 s
- 8 406;
- 9 (8) RCW 43.72.050 and 1993 c 492 s 407;
- 10 (9) RCW 43.72.060 and 1994 c 4 s 2 & 1993 c 492 s 404;
- 11 (10) RCW 43.72.070 and 1993 c 492 s 409;
- 12 (11) RCW 43.72.080 and 1993 c 492 s 425;
- 13 (12) RCW 43.72.090 and 1993 c 492 s 427;
- 14 (13) RCW 43.72.100 and 1993 c 492 s 428;
- 15 (14) RCW 43.72.110 and 1993 c 492 s 429;
- 16 (15) RCW 43.72.120 and 1993 c 492 s 430;
- 17 (16) RCW 43.72.130 and 1993 c 492 s 449;
- 18 (17) RCW 43.72.140 and 1993 c 492 s 450;
- 19 (18) RCW 43.72.150 and 1993 c 492 s 451;
- 20 (19) RCW 43.72.160 and 1993 c 492 s 452;
- 21 (20) RCW 43.72.170 and 1993 c 492 s 453;
- 22 (21) RCW 43.72.180 and 1993 c 492 s 454;
- 23 (22) RCW 43.72.190 and 1993 c 492 s 455;
- 24 (23) RCW 43.72.210 and 1993 c 492 s 463;
- 25 (24) RCW 43.72.220 and 1993 c 494 s 3 & 1993 c 492 s 464;
- 26 (25) RCW 43.72.225 and 1994 c 4 s 4;
- 27 (26) RCW 43.72.230 and 1993 c 492 s 465;
- 28 (27) RCW 43.72.240 and 1993 c 494 s 4 & 1993 c 492 s 466;
- 29 (28) RCW 43.72.300 and 1993 c 492 s 447;
- 30 (29) RCW 43.72.310 and 1993 c 492 s 448;
- 31 (30) RCW 43.72.800 and 1993 c 492 s 457;
- 32 (31) RCW 43.72.810 and 1993 c 492 s 474;
- 33 (32) RCW 43.72.820 and 1993 c 492 s 475;
- 34 (33) RCW 43.72.830 and 1993 c 492 s 476;
- 35 (34) RCW 43.72.840 and 1993 c 492 s 478;
- 36 (35) RCW 43.72.870 and 1993 c 494 s 5;
- 37 (36) RCW 48.01.200 and 1993 c 492 s 294;
- 38 (37) RCW 48.43.010 and 1993 c 492 s 432;
- 39 (38) RCW 48.43.020 and 1993 c 492 s 433;

- 1 (39) RCW 48.43.030 and 1993 c 492 s 434;  
2 (40) RCW 48.43.040 and 1993 c 492 s 435;  
3 (41) RCW 48.43.050 and 1993 c 492 s 436;  
4 (42) RCW 48.43.060 and 1993 c 492 s 437;  
5 (43) RCW 48.43.070 and 1993 c 492 s 438;  
6 (44) RCW 48.43.080 and 1993 c 492 s 439;  
7 (45) RCW 48.43.090 and 1993 c 492 s 440;  
8 (46) RCW 48.43.100 and 1993 c 492 s 441;  
9 (47) RCW 48.43.110 and 1993 c 492 s 442;  
10 (48) RCW 48.43.120 and 1993 c 492 s 443;  
11 (49) RCW 48.43.130 and 1993 c 492 s 444;  
12 (50) RCW 48.43.140 and 1993 c 492 s 445;  
13 (51) RCW 48.43.150 and 1993 c 492 s 446;  
14 (52) RCW 48.43.160 and 1993 c 492 s 426;  
15 (53) RCW 48.43.170 and 1993 c 492 s 431;  
16 (54) RCW 48.01.210 and 1993 c 462 s 51;  
17 (55) RCW 48.20.540 and 1993 c 492 s 283;  
18 (56) RCW 48.21.340 and 1993 c 492 s 284;  
19 (57) RCW 48.44.480 and 1993 c 492 s 285;  
20 (58) RCW 48.46.550 and 1993 c 492 s 286;  
21 (59) RCW 70.170.100 and 1993 c 492 s 259, 1990 c 269 s 12, & 1989  
22 1st ex.s. c 9 s 510;  
23 (60) RCW 70.170.110 and 1993 c 492 s 260 & 1989 1st ex.s. c 9 s  
24 511;  
25 (61) RCW 70.170.120 and 1993 c 492 s 261;  
26 (62) RCW 70.170.130 and 1993 c 492 s 262;  
27 (63) RCW 70.170.140 and 1993 c 492 s 263;  
28 (64) RCW 48.44.490 and 1993 c 492 s 288;  
29 (65) RCW 48.46.560 and 1993 c 492 s 289; and  
30 (66) RCW 43.72.200 and 1993 c 492 s 456.

31 NEW SECTION. **Sec. 28.** CODIFICATION DIRECTION. (1) Sections 2 and  
32 3 of this act shall constitute a new chapter in Title 48 RCW.

33 (2) Sections 4 through 7 and 25 of this act are each added to  
34 chapter 48.43 RCW.

35 (3) Sections 9 through 12 of this act shall constitute a new  
36 chapter in Title 43 RCW.

1 NEW SECTION. **Sec. 29.** CAPTIONS NOT LAW. Captions as used in this  
2 act constitute no part of the law.

3 NEW SECTION. **Sec. 30.** EFFECTIVE DATE. This act is necessary for  
4 the immediate preservation of the public peace, health, or safety, or  
5 support of the state government and its existing public institutions,  
6 and shall take effect July 1, 1995, except that sections 13 through 18  
7 of this act shall take effect January 1, 1996.

8 NEW SECTION. **Sec. 31.** SAVINGS CLAUSE. This act shall not be  
9 construed as affecting any existing right acquired or liability or  
10 obligation incurred under the sections amended or repealed in this act  
11 or under any rule or order adopted under those sections, nor as  
12 affecting any proceeding instituted under those sections.

13 NEW SECTION. **Sec. 32.** SEVERABILITY CLAUSE. If any provision of  
14 this act or its application to any person or circumstance is held  
15 invalid, the remainder of the act or the application of the provision  
16 to other persons or circumstances is not affected."

17 **ESHB 1046** - S AMD - 386  
18 By Senators Quigley, Deccio, Owen and Moyer

19 ADOPTED 4/14/95

20 On page 1, line 1 of the title, after "improvement;" strike the  
21 remainder of the title and insert "amending RCW 48.21.045, 48.44.023,  
22 and 48.46.066; adding a new section to chapter 70.47 RCW; adding new  
23 sections to chapter 48.43 RCW; adding a new section to chapter 48.20  
24 RCW; adding new sections to chapter 48.44 RCW; adding new sections to  
25 chapter 48.46 RCW; adding a new section to chapter 43.70 RCW; adding a  
26 new section to chapter 48.21 RCW; adding a new chapter to Title 48 RCW;  
27 adding a new chapter to Title 43 RCW; creating new sections; repealing  
28 RCW 18.130.320, 18.130.330, 43.72.005, 43.72.010, 43.72.020, 43.72.030,  
29 43.72.040, 43.72.050, 43.72.060, 43.72.070, 43.72.080, 43.72.090,  
30 43.72.100, 43.72.110, 43.72.120, 43.72.130, 43.72.140, 43.72.150,  
31 43.72.160, 43.72.170, 43.72.180, 43.72.190, 43.72.210, 43.72.220,  
32 43.72.225, 43.72.230, 43.72.240, 43.72.300, 43.72.310, 43.72.800,  
33 43.72.810, 43.72.820, 43.72.830, 43.72.840, 43.72.870, 48.01.200,  
34 48.43.010, 48.43.020, 48.43.030, 48.43.040, 48.43.050, 48.43.060,

1 48.43.070, 48.43.080, 48.43.090, 48.43.100, 48.43.110, 48.43.120,  
2 48.43.130, 70.170.140, 48.43.140, 48.43.150, 48.43.160, 48.43.170,  
3 48.01.210, 48.20.540, 48.21.340, 48.44.480, 48.46.550, 70.170.100,  
4 70.170.110, 70.170.120, 70.170.130, 70.170.140, 48.44.490, 48.46.560,  
5 and 43.72.200; providing effective dates; and declaring an emergency."

--- END ---