
SENATE BILL 6780

State of Washington 57th Legislature

2002 Regular Session

By Senators Parlette, Deccio, Carlson, Honeyford and West

Read first time 02/04/2002. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to offering a limited schedule of covered health
2 services to small employers or small groups; amending RCW 48.21.045,
3 48.44.023, 48.46.066, and 48.43.035; reenacting and amending RCW
4 48.43.005; and providing an effective date.

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

6 **Sec. 1.** RCW 48.21.045 and 1995 c 265 s 14 are each amended to read
7 as follows:

8 (1)(a) An insurer (~~offering any~~) may offer a health benefit plan
9 to a small employer (~~shall offer and actively market to the small~~
10 ~~employer a health benefit plan providing benefits identical to the~~),
11 as defined in RCW 48.43.005, featuring a limited schedule of covered
12 health services (~~that are required to be delivered to an individual~~
13 ~~enrolled in the basic health plan~~). Nothing in this subsection shall
14 preclude an insurer from offering, or a small employer from purchasing,
15 other health benefit plans that may have more (~~or less~~) comprehensive
16 benefits than (~~the basic health plan, provided such plans are in~~
17 ~~accordance with this chapter~~) those included in the product offered
18 under this section. An insurer offering a health benefit plan (~~that~~
19 ~~does not include benefits in the basic health plan~~) under this

1 subsection shall clearly disclose (~~these differences~~) all covered
2 benefits to the small employer in a brochure approved by the
3 commissioner.

4 (b) A health benefit plan offered under this subsection shall
5 provide coverage for hospital expenses and services rendered by a
6 physician licensed under chapter 18.57 or 18.71 RCW but (~~is not~~
7 ~~subject to the requirements of~~) will not include the services
8 identified in RCW 48.21.130, 48.21.140, (~~48.21.141,~~) 48.21.142,
9 48.21.144, 48.21.146, 48.21.148, 48.21.160 through 48.21.197,
10 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240,
11 48.21.244, 48.21.250, 48.21.300, 48.21.310, (~~or~~) 48.21.320 (~~if: (i)~~
12 ~~The health benefit plan is the mandatory offering under (a) of this~~
13 ~~subsection that provides benefits identical to the basic health plan,~~
14 ~~to the extent these requirements differ from the basic health plan; or~~
15 ~~(ii) the health benefit plan is offered to employers with not more than~~
16 ~~twenty-five employees~~), 48.43.045(1), 48.43.125, or 48.43.180.

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

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

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

- 28 (i) Geographic area;
- 29 (ii) Family size;
- 30 (iii) Age; (~~and~~)
- 31 (iv) Wellness activities;
- 32 (v) Industry; and
- 33 (vi) Any other factor that the commissioner finds to be
34 appropriate.

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~~
8 ~~groups on January 1, 1996, four hundred percent on January 1, 1997,~~
9 ~~and)) three hundred seventy-five percent of the lowest rate for all age
10 groups on January 1, 2000, and five hundred percent on January 1, 2003,
11 and thereafter.~~

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

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

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

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

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

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

24 (g) Rating factors shall produce premiums for identical groups that
25 differ only by the amounts attributable to plan design, with the
26 exception of discounts 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 similar
29 coverage to a health benefit plan that does not contain such a
30 provision, provided that the restrictions of benefits to network
31 providers result in substantial differences in claims costs. This
32 subsection does not restrict or enhance the portability of benefits as
33 provided in RCW 48.43.015.

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

36 (4) ~~((The health benefit plans authorized by this section that are~~
37 ~~lower than the required offering shall not supplant or supersede any~~
38 ~~existing policy for the benefit of employees in this state.)) Nothing~~
39 in this section shall restrict the right of employees to collectively

1 bargain for insurance providing benefits in excess of those provided
2 herein.

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

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

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

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

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

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

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

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

32 **Sec. 2.** RCW 48.43.005 and 2001 c 196 s 5 and 2001 c 147 s 1 are
33 each reenacted and amended to read as follows:

34 Unless otherwise specifically provided, the definitions in this
35 section apply throughout this chapter.

36 (1) "Adjusted community rate" means the rating method used to
37 establish the premium for health plans adjusted to reflect actuarially

1 demonstrated differences in utilization or cost attributable to
2 geographic region, age, family size, and use of wellness activities.

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

5 (3) "Basic health plan model plan" means a health plan as required
6 in RCW 70.47.060(2)(d).

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

11 (5) "Catastrophic health plan" means:

12 (a) In the case of a contract, agreement, or policy covering a
13 single enrollee, a health benefit plan requiring a calendar year
14 deductible of, at a minimum, one thousand five hundred dollars and an
15 annual out-of-pocket expense required to be paid under the plan (other
16 than for premiums) for covered benefits of at least three thousand
17 dollars; and

18 (b) In the case of a contract, agreement, or policy covering more
19 than one enrollee, a health benefit plan requiring a calendar year
20 deductible of, at a minimum, three thousand dollars and an annual out-
21 of-pocket expense required to be paid under the plan (other than for
22 premiums) for covered benefits of at least five thousand five hundred
23 dollars; or

24 (c) Any health benefit plan that provides benefits for hospital
25 inpatient and outpatient services, professional and prescription drugs
26 provided in conjunction with such hospital inpatient and outpatient
27 services, and excludes or substantially limits outpatient physician
28 services and those services usually provided in an office setting.

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

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

37 (8) "Covered person" or "enrollee" means a person covered by a
38 health plan including an enrollee, subscriber, policyholder,

1 beneficiary of a group plan, or individual covered by any other health
2 plan.

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

6 (10) "Eligible employee" means an employee who works on a full-time
7 basis with a normal work week of thirty or more hours. The term
8 includes a self-employed individual, including a sole proprietor, a
9 partner of a partnership, and may include an independent contractor, if
10 the self-employed individual, sole proprietor, partner, or independent
11 contractor is included as an employee under a health benefit plan of a
12 small employer, but does not work less than thirty hours per week and
13 derives at least seventy-five percent of his or her income from a trade
14 or business through which he or she has attempted to earn taxable
15 income and for which he or she has filed the appropriate internal
16 revenue service form. Persons covered under a health benefit plan
17 pursuant to the consolidated omnibus budget reconciliation act of 1986
18 shall not be considered eligible employees for purposes of minimum
19 participation requirements of chapter 265, Laws of 1995.

20 (11) "Emergency medical condition" means the emergent and acute
21 onset of a symptom or symptoms, including severe pain, that would lead
22 a prudent layperson acting reasonably to believe that a health
23 condition exists that requires immediate medical attention, if failure
24 to provide medical attention would result in serious impairment to
25 bodily functions or serious dysfunction of a bodily organ or part, or
26 would place the person's health in serious jeopardy.

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

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

34 (14) "Grievance" means a written complaint submitted by or on
35 behalf of a covered person regarding: (a) Denial of payment for
36 medical services or nonprovision of medical services included in the
37 covered person's health benefit plan, or (b) service delivery issues
38 other than denial of payment for medical services or nonprovision of
39 medical services, including dissatisfaction with medical care, waiting

1 time for medical services, provider or staff attitude or demeanor, or
2 dissatisfaction with service provided by the health carrier.

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

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

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

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

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

25 (18) "Health carrier" or "carrier" means a disability insurer
26 regulated under chapter 48.20 or 48.21 RCW, a health care service
27 contractor as defined in RCW 48.44.010, or a health maintenance
28 organization as defined in RCW 48.46.020.

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

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

33 (b) Medicare supplemental health insurance governed by chapter
34 48.66 RCW;

35 (c) Limited health care services offered by limited health care
36 service contractors in accordance with RCW 48.44.035;

37 (d) Disability income;

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

4 (f) Workers' compensation coverage;

5 (g) Accident only coverage;

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

8 (i) Employer-sponsored self-funded health plans;

9 (j) Dental only and vision only coverage; and

10 (k) Plans deemed by the insurance commissioner to have a short-term
11 limited purpose or duration, or to be a student-only plan that is
12 guaranteed renewable while the covered person is enrolled as a regular
13 full-time undergraduate or graduate student at an accredited higher
14 education institution, after a written request for such classification
15 by the carrier and subsequent written approval by the insurance
16 commissioner.

17 (20) "Material modification" means a change in the actuarial value
18 of the health plan as modified of more than five percent but less than
19 fifteen percent.

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

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

30 (23) "Review organization" means a disability insurer regulated
31 under chapter 48.20 or 48.21 RCW, health care service contractor as
32 defined in RCW 48.44.010, or health maintenance organization as defined
33 in RCW 48.46.020, and entities affiliated with, under contract with, or
34 acting on behalf of a health carrier to perform a utilization review.

35 (24) "Small employer" or "small group" means (~~(any person,)~~) a
36 firm, corporation, partnership, association, or political
37 subdivision(~~(, or self-employed individual)~~) that is actively engaged
38 in business that, on at least fifty percent of its working days during
39 the preceding calendar quarter, employed at least two but no more than

1 fifty eligible employees, with a normal work week of thirty or more
2 hours, the majority of whom were employed within this state, and is not
3 formed primarily for purposes of buying health insurance and in which
4 a bona fide employer-employee relationship exists. In determining the
5 number of eligible employees, companies that are affiliated companies,
6 or that are eligible to file a combined tax return for purposes of
7 taxation by this state, shall be considered an employer. Subsequent to
8 the issuance of a health plan to a small employer and for the purpose
9 of determining eligibility, the size of a small employer shall be
10 determined annually. Except as otherwise specifically provided, a
11 small employer shall continue to be considered a small employer until
12 the plan anniversary following the date the small employer no longer
13 meets the requirements of this definition. (~~The term "small employer"~~
14 ~~includes a self-employed individual or sole proprietor. The term~~
15 ~~"small employer" also includes a self-employed individual or sole~~
16 ~~proprietor who derives at least seventy five percent of his or her~~
17 ~~income from a trade or business through which the individual or sole~~
18 ~~proprietor has attempted to earn taxable income and for which he or she~~
19 ~~has filed the appropriate internal revenue service form 1040, schedule~~
20 ~~C or F, for the previous taxable year.))~~

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

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

33 **Sec. 3.** RCW 48.44.023 and 1995 c 265 s 16 are each amended to read
34 as follows:

35 (1)(a) A health care services contractor (~~offering any~~) may offer
36 a health benefit plan to a small employer (~~shall offer and actively~~
37 ~~market to the small employer a health benefit plan providing benefits~~
38 ~~identical to the~~), as defined in RCW 48.43.005, featuring a limited

1 schedule of covered health services (~~((that are required to be delivered~~
2 ~~to an individual enrolled in the basic health plan))~~). Nothing in this
3 subsection shall preclude a contractor 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,~~
6 ~~provided such plans are in accordance with this chapter)~~) those
7 included in the product offered under this section. A contractor
8 offering a health benefit plan (~~((that does not include benefits in the~~
9 ~~basic health plan))~~) under this subsection shall clearly disclose
10 (~~((these differences))~~) all covered benefits to the small employer in a
11 brochure approved by the commissioner.

12 (b) A health benefit plan offered under this subsection shall
13 provide coverage for hospital expenses and services rendered by a
14 physician licensed under chapter 18.57 or 18.71 RCW but (~~((is not~~
15 ~~subject to the requirements of)~~) will not include the services
16 identified in RCW 48.44.225, 48.44.240, 48.44.245, ((48.44.290,))
17 48.44.300, 48.44.310, 48.44.315, 48.44.320, 48.44.325, 48.44.330,
18 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440,
19 48.44.450, ((and)) 48.44.460 ((if: (i) 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; or (ii) the health benefit plan is~~
23 ~~offered to employers with not more than twenty five employees))~~,
24 48.44.500, 48.43.045(1), 48.43.125, or 48.43.180.

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

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

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

- 36 (i) Geographic area;
- 37 (ii) Family size;
- 38 (iii) Age; ((and))
- 39 (iv) Wellness activities;

1 (v) Industry; and
2 (vi) Any other factor that the commissioner finds to be
3 appropriate.

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

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

13 (d) The permitted rates for any age group shall be no more than
14 ~~((four hundred twenty five percent of the lowest rate for all age~~
15 ~~groups on January 1, 1996, four hundred percent on January 1, 1997,~~
16 ~~and)) three hundred seventy-five percent of the lowest rate for all age
17 groups on January 1, 2000, and five hundred percent on January 1, 2003,
18 and thereafter.~~

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

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

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

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

34 (h) For the purposes of this section, a health benefit plan that
35 contains a restricted network provision shall not be considered similar
36 coverage to a health benefit plan that does not contain such a
37 provision, provided that the restrictions of benefits to network
38 providers result in substantial differences in claims costs. This

1 subsection does not restrict or enhance the portability of benefits as
2 provided in RCW 48.43.015.

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

5 (4) ~~((The health benefit plans authorized by this section that are
6 lower than the required offering shall not supplant or supersede any
7 existing policy for the benefit of employees in this state.))~~ Nothing
8 in this section shall restrict the right of employees to collectively
9 bargain for insurance providing benefits in excess of those provided
10 herein.

11 (5)(a) Except as provided in this subsection, requirements used by
12 a contractor in determining whether to provide coverage to a small
13 employer shall be applied uniformly among all small employers applying
14 for coverage or 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 groups
20 with more than three employees.

21 (c) In applying minimum participation requirements with respect to
22 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 small
28 employer has been accepted for coverage.

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

37 **Sec. 4.** RCW 48.46.066 and 1995 c 265 s 18 are each amended to read
38 as follows:

1 (1)(a) A health maintenance organization (~~offering any~~) may offer
2 a health benefit plan to a small employer (~~shall offer and actively~~
3 ~~market to the small employer a health benefit plan providing benefits~~
4 ~~identical to the~~), as defined in RCW 48.43.005, featuring a limited
5 schedule of covered health services (~~that are required to be delivered~~
6 ~~to an individual enrolled in the basic health plan~~). Nothing in this
7 subsection shall preclude a health maintenance organization from
8 offering, or a small employer from purchasing, other health benefit
9 plans that may have more (~~or less~~) comprehensive benefits than (~~the~~
10 ~~basic health plan, provided such plans are in accordance with this~~
11 ~~chapter~~) those included in the product offered under this section. A
12 health maintenance organization offering a health benefit plan (~~that~~
13 ~~does not include benefits in the basic health plan~~) under this
14 subsection shall clearly disclose (~~these differences~~) all covered
15 benefits to the small employer in a brochure approved by the
16 commissioner.

17 (b) A health benefit plan offered under this subsection shall
18 provide coverage for hospital expenses and services rendered by a
19 physician licensed under chapter 18.57 or 18.71 RCW but (~~is not~~
20 ~~subject to the requirements of~~) will not include the services
21 identified in RCW 48.46.272, 48.46.275, 48.46.280, 48.46.285,
22 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480,
23 48.46.510, 48.46.520, (and) 48.46.530 (~~if: (i) The health benefit~~
24 ~~plan is the mandatory offering under (a) of this subsection that~~
25 ~~provides benefits identical to the basic health plan, to the extent~~
26 ~~these requirements differ from the basic health plan; or (ii) the~~
27 ~~health benefit plan is offered to employers with not more than twenty-~~
28 ~~five employees~~), 48.46.565, 48.46.570, 48.43.045(1), 48.43.125, and
29 48.43.180.

30 (2) Nothing in this section shall prohibit a health maintenance
31 organization from offering, or a purchaser from seeking, benefits in
32 excess of the (~~basic health plan services~~) health benefit plan
33 offered under subsection (1) of this section. All forms, policies, and
34 contracts shall be submitted for approval to the commissioner, and the
35 rates of any plan offered under subsection (1) of this section shall be
36 reasonable in relation to the benefits thereto.

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

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

4 (i) Geographic area;

5 (ii) Family size;

6 (iii) Age; (~~and~~)

7 (iv) Wellness activities;

8 (v) Industry; and

9 (vi) Any factor that the commissioner finds to be appropriate.

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

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

19 (d) The permitted rates for any age group shall be no more than
20 (~~four hundred twenty five percent of the lowest rate for all age~~
21 ~~groups on January 1, 1996, four hundred percent on January 1, 1997,~~
22 ~~and~~) three hundred seventy-five percent of the lowest rate for all age
23 groups on January 1, 2000, and five hundred percent on January 1, 2003,
24 and thereafter.

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

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

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

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

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

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

37 (g) Rating factors shall produce premiums for identical groups that
38 differ only by the amounts attributable to plan design, with the
39 exception of discounts 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 similar
3 coverage to a health benefit plan that does not contain such a
4 provision, provided that the restrictions of benefits to network
5 providers result in substantial differences in claims costs. This
6 subsection does not restrict or enhance the portability of benefits as
7 provided in RCW 48.43.015.

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

10 (4) (~~The health benefit plans authorized by this section that are~~
11 ~~lower than the required offering shall not supplant or supersede any~~
12 ~~existing policy for the benefit of employees in this state.)) Nothing
13 in this section shall restrict the right of employees to collectively
14 bargain for insurance providing benefits in excess of those provided
15 herein.~~

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

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

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

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

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

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

35 (6) A health maintenance organization must offer coverage to all
36 eligible employees of a small employer and their dependents. A health
37 maintenance organization may not offer coverage to only certain
38 individuals or dependents in a small employer group or to only part of
39 the group. A health maintenance organization may not modify a health

1 plan with respect to a small employer or any eligible employee or
2 dependent, through riders, endorsements or otherwise, to restrict or
3 exclude coverage or benefits for specific diseases, medical conditions,
4 or services otherwise covered by the plan.

5 **Sec. 5.** RCW 48.43.035 and 2000 c 79 s 24 are each amended to read
6 as follows:

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

8 (1) All health carriers shall accept for enrollment any state
9 resident within the group to whom the plan is offered and within the
10 carrier's service area and provide or assure the provision of all
11 covered services regardless of age, sex, family structure, ethnicity,
12 race, health condition, geographic location, employment status,
13 socioeconomic status, other condition or situation, or the provisions
14 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
15 exemption from this subsection, if, upon application by a health
16 carrier the commissioner finds that the clinical, financial, or
17 administrative capacity to serve existing enrollees will be impaired if
18 a health carrier is required to continue enrollment of additional
19 eligible individuals.

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

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

31 (a) Nonpayment of premium;

32 (b) Violation of published policies of the carrier approved by the
33 insurance commissioner;

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

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

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

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

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

8 (4) (~~The provisions of~~) This section (~~do~~) does not apply in the
9 following cases:

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

11 (b) For group health plans sold to groups other than small employer
12 groups, a carrier replaces a product and the replacement product is
13 provided to all covered persons within that class or line of business,
14 includes all of the services covered under the replaced product, and
15 does not significantly limit access to the kind of services covered
16 under the replaced product. The health plan may also allow
17 unrestricted conversion to a fully comparable product; or

18 (c) For group health plans offered to small employer groups, no
19 sooner than October 1, 2002, a carrier discontinues offering a
20 particular type of health benefit plan if: (i) The carrier provides
21 notice to each group provided coverage of this type of the
22 discontinuation at least ninety days prior to the date of the
23 discontinuation; (ii) the carrier offers to each group provided
24 coverage of this type the option to enroll in any other small employer
25 group health benefit plan currently being offered by the carrier; and
26 (iii) in exercising the option to discontinue coverage of this type and
27 in offering the option of coverage under (c)(ii) of this subsection,
28 the carrier acts uniformly without regard to any health status-related
29 factor of individuals enrolled through the small employer group,
30 individuals who may become eligible for such coverage, or the
31 collective health status of groups enrolled in coverage of this type;
32 or

33 (d) A carrier discontinues offering all small employer group health
34 coverage in the state and discontinues coverage under all existing
35 small employer group health benefit plans if: (i) The carrier provides
36 notice to the commissioner of its intent to discontinue offering all
37 small employer group health coverage in the state and its intent to
38 discontinue coverage under all existing health benefit plans at least
39 one hundred eighty days prior to the date of the discontinuation of

1 coverage under all existing health benefit plans; and (ii) the carrier
2 provides notice to each covered small employer group of the intent to
3 discontinue his or her existing health benefit plan at least one
4 hundred eighty days prior to the date of the discontinuation and
5 includes information in the notice that can help the small employer
6 group identify alternative sources of coverage. In the case of
7 discontinuation under this subsection, the carrier may not issue any
8 small employer group health coverage in this state for a five-year
9 period beginning on the date of the discontinuation of the last health
10 plan not so renewed. Nothing in this subsection (3) may be construed
11 to require a carrier to provide notice to the commissioner of its
12 intent to discontinue offering a health benefit plan to new applicants
13 where the carrier does not discontinue coverage of existing enrollees
14 under that health benefit plan; or

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

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

24 NEW SECTION. Sec. 6. Section 5 of this act takes effect January
25 1, 2004.

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