

SHB 2460 - H AMD 999

By Representative Cody

ADOPTED 02/17/2004

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

3 "Sec. 1. RCW 48.21.045 and 1995 c 265 s 14 are each amended to
4 read as follows:

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

20 (b) A health benefit plan offered under this subsection shall
21 provide coverage for hospital expenses and services rendered by a
22 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
23 to the requirements of RCW (~~48.21.130,~~) 48.21.140, (~~48.21.141,~~)
24 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197,
25 48.21.200, 48.21.220, (~~48.21.225, 48.21.230, 48.21.235,~~) 48.21.240,
26 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320 (~~if: (i) The~~
27 ~~health benefit plan is the mandatory offering under (a) of this~~
28 ~~subsection that provides benefits identical to the basic health plan,~~
29 ~~to the extent these requirements differ from the basic health plan; or~~

1 ~~(ii) the health benefit plan is offered to~~) for employers with not
2 more than ~~((twenty-five))~~ fifty employees.

3 (2) Nothing in this section shall prohibit an insurer from
4 offering, or a purchaser from seeking, health benefit plans with
5 benefits in excess of the ~~((basic health plan services))~~ health benefit
6 plan offered under subsection (1) of this section. All forms,
7 policies, and contracts shall be submitted for approval to the
8 commissioner, and the rates of any plan offered under this section
9 shall be reasonable in relation to the benefits thereto.

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

12 (a) The insurer shall develop its rates based on an adjusted
13 community rate and may only vary the adjusted 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. Employees under the age
21 of twenty shall be treated as those age twenty.

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

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 enrollment of the small employer;

1 (ii) Changes to the family composition of the employee;
2 (iii) Changes to the health benefit plan requested by the small
3 employer; or
4 (iv) Changes in government requirements affecting the health
5 benefit plan.

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

9 (h) For the purposes of this section, a health benefit plan that
10 contains a restricted network provision shall not be considered similar
11 coverage to a health benefit plan that does not contain such a
12 provision, provided that the restrictions of benefits to network
13 providers result in substantial differences in claims costs. A carrier
14 may develop its rates based on claims costs due to network provider
15 reimbursement schedules or type of network. This subsection does not
16 restrict or enhance the portability of benefits as provided in RCW
17 48.43.015.

18 (i) Adjusted community rates established under this section shall
19 pool the medical experience of all small groups purchasing coverage
20 including the development of allowable factors under (a) and (h) of
21 this subsection. The development of these factors or benefit
22 relativities must be based on the carrier's company-wide credible study
23 or a large study developed by an actuarial consultant or other method
24 accepted by the commissioner.

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

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

35 (b) An insurer shall not require a minimum participation level
36 greater than:

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

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

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

9 (d) An insurer may not increase any requirement for minimum
10 employee participation or modify any requirement for minimum employer
11 contribution applicable to a small employer at any time after the small
12 employer has been accepted for coverage.

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

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

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

26 Unless otherwise specifically provided, the definitions in this
27 section apply throughout this chapter.

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

32 (2) "Basic health plan" means the plan described under chapter
33 70.47 RCW, as revised from time to time.

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

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

5 (5) "Catastrophic health plan" means:

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

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

18 (c) Any health benefit plan that provides benefits for hospital
19 inpatient and outpatient services, professional and prescription drugs
20 provided in conjunction with such hospital inpatient and outpatient
21 services, and excludes or substantially limits outpatient physician
22 services and those services usually provided in an office setting.

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

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

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

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

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

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

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

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

29 (14) "Grievance" means a written complaint submitted by or on
30 behalf of a covered person regarding: (a) Denial of payment for
31 medical services or nonprovision of medical services included in the
32 covered person's health benefit plan, or (b) service delivery issues
33 other than denial of payment for medical services or nonprovision of
34 medical services, including dissatisfaction with medical care, waiting
35 time for medical services, provider or staff attitude or demeanor, or
36 dissatisfaction with service provided by the health carrier.

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

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

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

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

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

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

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

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

31 (b) Medicare supplemental health insurance governed by chapter
32 48.66 RCW;

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

35 (d) Disability income;

36 (e) Coverage incidental to a property/casualty liability insurance

1 policy such as automobile personal injury protection coverage and
2 homeowner guest medical;

3 (f) Workers' compensation coverage;

4 (g) Accident only coverage;

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

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

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

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

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

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

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

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

34 (24) "Small employer" or "small group" means any person, firm,
35 corporation, partnership, association, political subdivision, sole
36 proprietor, or self-employed individual that is actively engaged in
37 business that, on at least fifty percent of its working days during the

1 preceding calendar quarter, employed at least two but no more than
2 fifty eligible employees, with a normal work week of thirty or more
3 hours, the majority of whom were employed within this state, and is not
4 formed primarily for purposes of buying health insurance and in which
5 a bona fide employer-employee relationship exists. In determining the
6 number of eligible employees, companies that are affiliated companies,
7 or that are eligible to file a combined tax return for purposes of
8 taxation by this state, shall be considered an employer. Subsequent to
9 the issuance of a health plan to a small employer and for the purpose
10 of determining eligibility, the size of a small employer shall be
11 determined annually. Except as otherwise specifically provided, a
12 small employer shall continue to be considered a small employer until
13 the plan anniversary following the date the small employer no longer
14 meets the requirements of this definition. (~~The term "small employer"~~
15 ~~includes a self-employed individual or sole proprietor. The term~~
16 ~~"small employer" also includes a self-employed individual or sole~~
17 ~~proprietor who derives at least seventy five percent of his or her~~
18 ~~income from a trade or business through which the individual or sole~~
19 ~~proprietor has attempted to earn taxable income and for which he or she~~
20 ~~has filed the appropriate internal revenue service form 1040, schedule~~
21 ~~C or F, for the previous taxable year.)) A self-employed individual or
22 sole proprietor who is covered as a group of one on the day prior to
23 the effective date of this section shall also be considered a "small
24 employer" to the extent that individual or group of one is entitled to
25 have his or her coverage renewed as provided in RCW 48.43.035(6).~~

26 (25) "Utilization review" means the prospective, concurrent, or
27 retrospective assessment of the necessity and appropriateness of the
28 allocation of health care resources and services of a provider or
29 facility, given or proposed to be given to an enrollee or group of
30 enrollees.

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

1 **Sec. 3.** RCW 48.43.018 and 2001 c 196 s 8 are each amended to read
2 as follows:

3 (1) Except as provided in (a) through ~~((c))~~ (d) of this
4 subsection, a health carrier may require any person applying for an
5 individual health benefit plan to complete the standard health
6 questionnaire designated under chapter 48.41 RCW.

7 (a) If a person is seeking an individual health benefit plan due to
8 his or her change of residence from one geographic area in Washington
9 state to another geographic area in Washington state where his or her
10 current health plan is not offered, completion of the standard health
11 questionnaire shall not be a condition of coverage if application for
12 coverage is made within ninety days of relocation.

13 (b) If a person is seeking an individual health benefit plan:

14 (i) Because a health care provider with whom he or she has an
15 established care relationship and from whom he or she has received
16 treatment within the past twelve months is no longer part of the
17 carrier's provider network under his or her existing Washington
18 individual health benefit plan; and

19 (ii) His or her health care provider is part of another carrier's
20 provider network; and

21 (iii) Application for a health benefit plan under that carrier's
22 provider network individual coverage is made within ninety days of his
23 or her provider leaving the previous carrier's provider network; then
24 completion of the standard health questionnaire shall not be a
25 condition of coverage.

26 (c) If a person is seeking an individual health benefit plan due to
27 his or her having exhausted continuation coverage provided under 29
28 U.S.C. Sec. 1161 et seq., or is part of a small employer group of less
29 than twenty employees, and meets the federal standards of eligibility
30 for continuation coverage, completion of the standard health
31 questionnaire shall not be a condition of coverage if application for
32 coverage is made within ninety days of exhaustion of continuation
33 coverage. A health carrier shall accept an application without a
34 standard health questionnaire from a person currently covered by such
35 continuation coverage if application is made within ninety days prior
36 to the date the continuation coverage would be exhausted and the

1 effective date of the individual coverage applied for is the date the
2 continuation coverage would be exhausted, or within ninety days
3 thereafter.

4 (d) If a person is seeking an individual health benefit plan due to
5 his or her receiving notice that his or her coverage under a conversion
6 contract is discontinued, completion of the standard health
7 questionnaire shall not be a condition of coverage if application for
8 coverage is made within ninety days of discontinuation of eligibility
9 under the conversion contract. A health carrier shall accept an
10 application without a standard health questionnaire from a person
11 currently covered by such conversion contract if application is made
12 within ninety days prior to the date eligibility under the conversion
13 contract would be discontinued and the effective date of the individual
14 coverage applied for is the date eligibility under the conversion
15 contract would be discontinued, or within ninety days thereafter.

16 (2) If, based upon the results of the standard health
17 questionnaire, the person qualifies for coverage under the Washington
18 state health insurance pool, the following shall apply:

19 (a) The carrier may decide not to accept the person's application
20 for enrollment in its individual health benefit plan; and

21 (b) Within fifteen business days of receipt of a completed
22 application, the carrier shall provide written notice of the decision
23 not to accept the person's application for enrollment to both the
24 person and the administrator of the Washington state health insurance
25 pool. The notice to the person shall state that the person is eligible
26 for health insurance provided by the Washington state health insurance
27 pool, and shall include information about the Washington state health
28 insurance pool and an application for such coverage. If the carrier
29 does not provide or postmark such notice within fifteen business days,
30 the application is deemed approved.

31 (3) If the person applying for an individual health benefit plan:

32 (a) Does not qualify for coverage under the Washington state health
33 insurance pool based upon the results of the standard health
34 questionnaire; (b) does qualify for coverage under the Washington state
35 health insurance pool based upon the results of the standard health
36 questionnaire and the carrier elects to accept the person for
37 enrollment; or (c) is not required to complete the standard health

1 questionnaire designated under this chapter under subsection (1)(a) or
2 (b) of this section, the carrier shall accept the person for enrollment
3 if he or she resides within the carrier's service area and provide or
4 assure the provision of all covered services regardless of age, sex,
5 family structure, ethnicity, race, health condition, geographic
6 location, employment status, socioeconomic status, other condition or
7 situation, or the provisions of RCW 49.60.174(2). The commissioner may
8 grant a temporary exemption from this subsection if, upon application
9 by a health carrier, the commissioner finds that the clinical,
10 financial, or administrative capacity to serve existing enrollees will
11 be impaired if a health carrier is required to continue enrollment of
12 additional eligible individuals.

13 **Sec. 4.** RCW 48.43.035 and 2000 c 79 s 24 are each amended to read
14 as follows:

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

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

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

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

4 (a) Nonpayment of premium;

5 (b) Violation of published policies of the carrier approved by the
6 insurance commissioner;

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

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

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

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

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

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

20 (a) A carrier has zero enrollment on a product; (~~(e)~~)

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

27 (c) No sooner than January 1, 2005, a carrier discontinues offering
28 a particular type of health benefit plan offered for groups of up to
29 two hundred if: (i) The carrier provides notice to each group of the
30 discontinuation at least ninety days prior to the date of the
31 discontinuation; (ii) the carrier offers to each group provided
32 coverage of this type the option to enroll, with regard to small
33 employer groups, in any other small employer group plan, or with regard
34 to groups of up to two hundred, in any other applicable group plan,
35 currently being offered by the carrier in the applicable group market;
36 and (iii) in exercising the option to discontinue coverage of this type
37 and in offering the option of coverage under (c)(ii) of this

1 subsection, the carrier acts uniformly without regard to any health
2 status-related factor of enrolled individuals or individuals who may
3 become eligible for this coverage;

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

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

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

33 (6) Notwithstanding any other provision of this section, the
34 guarantee of continuity of coverage applies to a group of one only if:
35 (a) The carrier continues to offer any other small employer group plan
36 in which the group of one was eligible to enroll on the day prior to

1 the effective date of this section; and (b) the person continues to
2 qualify as a group of one under the criteria in place on the day prior
3 to the effective date of this section.

4 **Sec. 5.** RCW 48.43.038 and 2000 c 79 s 25 are each amended to read
5 as follows:

6 (1) Except as provided in subsection (4) of this section, all
7 individual health plans shall contain or incorporate by endorsement a
8 guarantee of the continuity of coverage of the plan. For the purposes
9 of this section, a plan is "renewed" when it is continued beyond the
10 earliest date upon which, at the carrier's sole option, the plan could
11 have been terminated for other than nonpayment of premium.

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

15 (a) Nonpayment of premium;

16 (b) Violation of published policies of the carrier approved by the
17 commissioner;

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

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

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

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

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

29 (3) This section does not apply in the following cases:

30 (a) A carrier has zero enrollment on a product;

31 (b) 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 commissioner that the carrier's clinical, financial, or administrative
34 capacity to serve enrollees would be exceeded;

35 (c) No sooner than the first day of the month following the
36 expiration of a one hundred eighty-day period beginning on March 23,

1 2000, a carrier discontinues offering a particular type of health
2 benefit plan offered in the individual market, including conversion
3 contracts, if: (i) The carrier provides notice to each covered
4 individual provided coverage of this type of such discontinuation at
5 least ninety days prior to the date of the discontinuation; (ii) the
6 carrier offers to each individual provided coverage of this type the
7 option, without being subject to the standard health questionnaire, to
8 enroll in any other individual health benefit plan currently being
9 offered by the carrier; and (iii) in exercising the option to
10 discontinue coverage of this type and in offering the option of
11 coverage under (c)(ii) of this subsection, the carrier acts uniformly
12 without regard to any health status-related factor of enrolled
13 individuals or individuals who may become eligible for such coverage;
14 or

15 (d) A carrier discontinues offering all individual health coverage
16 in the state and discontinues coverage under all existing individual
17 health benefit plans if: (i) The carrier provides notice to the
18 commissioner of its intent to discontinue offering all individual
19 health coverage in the state and its intent to discontinue coverage
20 under all existing health benefit plans at least one hundred eighty
21 days prior to the date of the discontinuation of coverage under all
22 existing health benefit plans; and (ii) the carrier provides notice to
23 each covered individual of the intent to discontinue his or her
24 existing health benefit plan at least one hundred eighty days prior to
25 the date of such discontinuation. In the case of discontinuation under
26 this subsection, the carrier may not issue any individual health
27 coverage in this state for a five-year period beginning on the date of
28 the discontinuation of the last health plan not so renewed. Nothing in
29 this subsection (3) shall be construed to require a carrier to provide
30 notice to the commissioner of its intent to discontinue offering a
31 health benefit plan to new applicants where the carrier does not
32 discontinue coverage of existing enrollees under that health benefit
33 plan.

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

1 **Sec. 6.** RCW 48.44.022 and 2000 c 79 s 30 are each amended to read
2 as follows:

3 (1) Premium rates for health benefit plans for individuals shall be
4 subject to the following provisions:

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

8 (i) Geographic area;

9 (ii) Family size;

10 (iii) Age;

11 (iv) Tenure discounts; and

12 (v) Wellness activities.

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

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

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

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

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

32 (i) Changes to the family composition;

33 (ii) Changes to the health benefit plan requested by the
34 individual; or

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

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

10 (2) 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 48.44.023.

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

17 **Sec. 7.** RCW 48.44.023 and 1995 c 265 s 16 are each amended to read
18 as follows:

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

34 (b) A health benefit plan offered under this subsection shall
35 provide coverage for hospital expenses and services rendered by a
36 physician licensed under chapter 18.57 or 18.71 RCW but is not subject

1 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245,
2 ((~~48.44.290, 48.44.300,~~)) 48.44.310, 48.44.320, ((~~48.44.325, 48.44.330,~~
3 ~~48.44.335,~~)) 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440,
4 48.44.450, and 48.44.460 ((~~if: (i) The health benefit plan is the~~
5 ~~mandatory offering under (a) of this subsection that provides benefits~~
6 ~~identical to the basic health plan, to the extent these requirements~~
7 ~~differ from the basic health plan; or (ii) the health benefit plan is~~
8 ~~offered to~~)) for employers with not more than ((~~twenty five~~)) fifty
9 employees.

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

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

19 (a) The contractor shall develop its rates based on an adjusted
20 community rate and may only vary the adjusted 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. Employees under the age
28 of twenty shall be treated as those age twenty.

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

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 enrollment of the small employer;

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

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

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

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

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

25 (i) Adjusted community rates established under this section shall
26 pool the medical experience of all groups purchasing coverage including
27 the development of allowable factors under (a) and (h) of this
28 subsection. The development of these factors or benefit relativities
29 must be based on the carrier's company-wide credible study or a large
30 study developed by an actuarial consultant or other method accepted by
31 the commissioner.

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

1 (5)(a) Except as provided in this subsection, requirements used by
2 a contractor 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) A contractor 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) A contractor 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) A contractor must offer coverage to all eligible employees of
20 a small employer and their dependents. A contractor may not offer
21 coverage to only certain individuals or dependents in a small employer
22 group or to only part of the group. A contractor may not modify a
23 health plan with respect to a small employer or any eligible employee
24 or dependent, through riders, endorsements or otherwise, to restrict or
25 exclude coverage or benefits for specific diseases, medical conditions,
26 or services otherwise covered by the plan.

27 (7) As used in this section, "health benefit plan," "small
28 employer," and "wellness activities" mean the same as defined in RCW
29 48.43.005.

30 **Sec. 8.** RCW 48.46.064 and 2000 c 79 s 33 are each amended to read
31 as follows:

32 (1) Premium rates for health benefit plans for individuals shall be
33 subject to the following provisions:

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

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

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

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

15 (d) The permitted rates for any age group shall be no more than
16 four hundred twenty-five percent of the lowest rate for all age groups
17 on January 1, 1996, four hundred percent on January 1, 1997, and three
18 hundred seventy-five percent on January 1, 2000, 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 family composition;
26 (ii) Changes to the health benefit plan requested by the
27 individual; or
28 (iii) Changes in government requirements affecting the health
29 benefit plan.

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

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

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

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

10 **Sec. 9.** RCW 48.46.066 and 1995 c 265 s 18 are each amended to read
11 as follows:

12 (1)(a) A health maintenance organization offering any health
13 benefit plan to a small employer (~~shall~~) may offer and actively
14 market to the small employer a health benefit plan (~~providing benefits~~
15 ~~identical to the schedule of covered health services that are required~~
16 ~~to be delivered to an individual enrolled in the basic health plan~~)
17 featuring a limited schedule of covered health care services. Nothing
18 in this subsection shall preclude a health maintenance organization
19 from offering, or a small employer from purchasing, other health
20 benefit plans that may have more (~~or less~~) comprehensive benefits
21 than (~~the basic health plan, provided such plans are in accordance~~
22 ~~with this chapter~~) those included in the product offered under this
23 subsection. A health maintenance organization offering a health
24 benefit plan (~~that does not include benefits in the basic health~~
25 ~~plan~~) under this subsection shall clearly disclose (~~these~~
26 ~~differences~~) all the covered benefits to the small employer in a
27 brochure (~~approved by~~) filed with the commissioner.

28 (b) A health benefit plan offered under this subsection shall
29 provide coverage for hospital expenses and services rendered by a
30 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
31 to the requirements of RCW (~~48.46.275, 48.46.280, 48.46.285,~~)
32 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480,
33 48.46.510, 48.46.520, and 48.46.530 (~~if: (i) The health benefit plan~~
34 ~~is the mandatory offering under (a) of this subsection that provides~~
35 ~~benefits identical to the basic health plan, to the extent these~~

1 ~~requirements differ from the basic health plan; or (ii) the health~~
2 ~~benefit plan is offered to))~~ for employers with not more than (~~twenty-~~
3 ~~five))~~ fifty employees.

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

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

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

- 16 (i) Geographic area;
- 17 (ii) Family size;
- 18 (iii) Age; and
- 19 (iv) Wellness activities.

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

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

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

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

36 (f) The rate charged for a health benefit plan offered under this

1 section may not be adjusted more frequently than annually except that
2 the premium may be changed to reflect:

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

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

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

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

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

12 (h) 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. A carrier
17 may develop its rates based on claims costs due to network provider
18 reimbursement schedules or type of network. This subsection does not
19 restrict or enhance the portability of benefits as provided in RCW
20 48.43.015.

21 (i) Adjusted community rates established under this section shall
22 pool the medical experience of all groups purchasing coverage including
23 the development of allowable factors under (a) and (h) of this
24 subsection. The development of these factors or benefit relativities
25 must be based on the carrier's company-wide credible study or a large
26 study developed by an actuarial consultant or other method accepted by
27 the commissioner.

28 ~~(4) ((The health benefit plans authorized by this section that are~~
29 ~~lower than the required offering shall not supplant or supersede any~~
30 ~~existing policy for the benefit of employees in this state.))~~ Nothing
31 in this section shall restrict the right of employees to collectively
32 bargain for insurance providing benefits in excess of those provided
33 herein.

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

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

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

5 (ii) Seventy-five percent of eligible employees working for 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 health maintenance organization may not increase any
12 requirement for minimum employee participation or modify any
13 requirement for minimum employer contribution applicable to a small
14 employer at any time after the small employer has been accepted for
15 coverage.

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

25 (7) As used in this section, "health benefit plan," "small
26 employer," and "wellness activities" mean the same as defined in RCW
27 48.43.005.

28 NEW SECTION. Sec. 10. The following acts or parts of acts are
29 each repealed:

30 (1) RCW 48.21.260 (Conversion policy to be offered--Exceptions,
31 conditions) and 1984 c 190 s 3;

32 (2) RCW 48.21.270 (Conversion policy--Restrictions and
33 requirements) and 1984 c 190 s 4;

34 (3) RCW 48.44.370 (Conversion contract to be offered--Exceptions,
35 conditions) and 1984 c 190 s 6;

1 (4) RCW 48.44.380 (Conversion contract--Restrictions and
2 requirements) and 1984 c 190 s 7;

3 (5) RCW 48.46.450 (Conversion agreement to be offered--Exceptions,
4 conditions) and 1984 c 190 s 9; and

5 (6) RCW 48.46.460 (Conversion agreement--Restrictions and
6 requirements) and 1984 c 190 s 10.

7 NEW SECTION. **Sec. 11.** Sections 1 through 9 of this act apply to
8 all small group health benefit plans issued or renewed on or after the
9 effective date of this section."

10 Correct the title.

--- END ---