2460-S.E AMS DECC S5004.4

ESHB 2460 - S AMD **760**
By Senator Deccio

ADOPTED 03/03/2004

Strike everything after the enacting clause and insert the following:

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

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

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

~~(2)~~)) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care,

may offer and actively market to the small employer no more than one health benefit plan including a limited schedule of covered health care services.

(a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to comply with: RCW 48.21.130 through 48.21.240, 48.21.244 through 48.21.280, 48.21.300 through 48.21.320, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the insurer must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) An insurer offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is

the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection ((~~(3)~~)) (4).

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

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

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

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

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

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

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

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

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

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

((~~(4) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) However, adjustments for each small group health benefit plan may vary by up to plus or minus ten percentage points from the overall adjustment of the carrier's entire small group pool upon a showing by the carrier, certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, or

provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than ten percentage points from the overall adjustment of the carrier's entire small group pool must be approved by the commissioner.

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

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

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

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

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

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

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

((~~(6)~~)) (7) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

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

1 **Sec. 2.** RCW 48.43.005 and 2001 c 196 s 5 and 2001 c 147 s 1 are
2 each reenacted and amended to read as follows:
3 Unless otherwise specifically provided, the definitions in this
4 section apply throughout this chapter.
5 (1) "Adjusted community rate" means the rating method used to
6 establish the premium for health plans adjusted to reflect actuarially
7 demonstrated differences in utilization or cost attributable to
8 geographic region, age, family size, and use of wellness activities.
9 (2) "Basic health plan" means the plan described under chapter
10 70.47 RCW, as revised from time to time.
11 (3) "Basic health plan model plan" means a health plan as required
12 in RCW 70.47.060(2)(d).
13 (4) "Basic health plan services" means that schedule of covered
14 health services, including the description of how those benefits are to
15 be administered, that are required to be delivered to an enrollee under
16 the basic health plan, as revised from time to time.
17 (5) "Catastrophic health plan" means:
18 (a) In the case of a contract, agreement, or policy covering a
19 single enrollee, a health benefit plan requiring a calendar year
20 deductible of, at a minimum, one thousand five hundred dollars and an
21 annual out-of-pocket expense required to be paid under the plan (other
22 than for premiums) for covered benefits of at least three thousand
23 dollars; and
24 (b) In the case of a contract, agreement, or policy covering more
25 than one enrollee, a health benefit plan requiring a calendar year
26 deductible of, at a minimum, three thousand dollars and an annual out-
27 of-pocket expense required to be paid under the plan (other than for
28 premiums) for covered benefits of at least five thousand five hundred
29 dollars; or
30 (c) Any health benefit plan that provides benefits for hospital
31 inpatient and outpatient services, professional and prescription drugs
32 provided in conjunction with such hospital inpatient and outpatient
33 services, and excludes or substantially limits outpatient physician
34 services and those services usually provided in an office setting.
35 (6) "Certification" means a determination by a review organization
36 that an admission, extension of stay, or other health care service or
37 procedure has been reviewed and, based on the information provided,
38 meets the clinical requirements for medical necessity, appropriateness,

1 level of care, or effectiveness under the auspices of the applicable
2 health benefit plan.
3 (7) "Concurrent review" means utilization review conducted during
4 a patient's hospital stay or course of treatment.
5 (8) "Covered person" or "enrollee" means a person covered by a
6 health plan including an enrollee, subscriber, policyholder,
7 beneficiary of a group plan, or individual covered by any other health
8 plan.
9 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
10 and unmarried dependent children who qualify for coverage under the
11 enrollee's health benefit plan.
12 (10) "Eligible employee" means an employee who works on a full-time
13 basis with a normal work week of thirty or more hours. The term
14 includes a self-employed individual, including a sole proprietor, a
15 partner of a partnership, and may include an independent contractor, if
16 the self-employed individual, sole proprietor, partner, or independent
17 contractor is included as an employee under a health benefit plan of a
18 small employer, but does not work less than thirty hours per week and
19 derives at least seventy-five percent of his or her income from a trade
20 or business through which he or she has attempted to earn taxable
21 income and for which he or she has filed the appropriate internal
22 revenue service form. Persons covered under a health benefit plan
23 pursuant to the consolidated omnibus budget reconciliation act of 1986
24 shall not be considered eligible employees for purposes of minimum
25 participation requirements of chapter 265, Laws of 1995.
26 (11) "Emergency medical condition" means the emergent and acute
27 onset of a symptom or symptoms, including severe pain, that would lead
28 a prudent layperson acting reasonably to believe that a health
29 condition exists that requires immediate medical attention, if failure
30 to provide medical attention would result in serious impairment to
31 bodily functions or serious dysfunction of a bodily organ or part, or
32 would place the person's health in serious jeopardy.
33 (12) "Emergency services" means otherwise covered health care
34 services medically necessary to evaluate and treat an emergency medical
35 condition, provided in a hospital emergency department.
36 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
37 health carriers directly providing services, health care providers, or
38 health care facilities by enrollees and may include copayments,
39 coinsurance, or deductibles.

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

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

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

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

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

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

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

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

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

1 (b) Medicare supplemental health insurance governed by chapter
2 48.66 RCW;
3 (c) Limited health care services offered by limited health care
4 service contractors in accordance with RCW 48.44.035;
5 (d) Disability income;
6 (e) Coverage incidental to a property/casualty liability insurance
7 policy such as automobile personal injury protection coverage and
8 homeowner guest medical;
9 (f) Workers' compensation coverage;
10 (g) Accident only coverage;
11 (h) Specified disease and hospital confinement indemnity when
12 marketed solely as a supplement to a health plan;
13 (i) Employer-sponsored self-funded health plans;
14 (j) Dental only and vision only coverage; and
15 (k) Plans deemed by the insurance commissioner to have a short-term
16 limited purpose or duration, or to be a student-only plan that is
17 guaranteed renewable while the covered person is enrolled as a regular
18 full-time undergraduate or graduate student at an accredited higher
19 education institution, after a written request for such classification
20 by the carrier and subsequent written approval by the insurance
21 commissioner.
22 (20) "Material modification" means a change in the actuarial value
23 of the health plan as modified of more than five percent but less than
24 fifteen percent.
25 (21) "Preexisting condition" means any medical condition, illness,
26 or injury that existed any time prior to the effective date of
27 coverage.
28 (22) "Premium" means all sums charged, received, or deposited by a
29 health carrier as consideration for a health plan or the continuance of
30 a health plan. Any assessment or any "membership," "policy,"
31 "contract," "service," or similar fee or charge made by a health
32 carrier in consideration for a health plan is deemed part of the
33 premium. "Premium" shall not include amounts paid as enrollee point-
34 of-service cost-sharing.
35 (23) "Review organization" means a disability insurer regulated
36 under chapter 48.20 or 48.21 RCW, health care service contractor as
37 defined in RCW 48.44.010, or health maintenance organization as defined
38 in RCW 48.46.020, and entities affiliated with, under contract with, or
39 acting on behalf of a health carrier to perform a utilization review.

(24) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. ((~~The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes~~)) A self-employed individual or sole proprietor ((~~who~~)) must derive((~~s~~)) at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to the effective date of this act shall also be considered a "small employer" to the extent that an individual or group of one may have his or her coverage renewed as provided in RCW 48.43.035(6).

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

(26) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle

safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

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

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

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

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

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

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

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

(c) If a person is seeking an individual health benefit plan due to his or her having exhausted continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of exhaustion of continuation coverage. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such continuation coverage if application is made within ninety days prior to the date the continuation coverage would be exhausted and the

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

(d) If a person is seeking an individual health benefit plan and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

(e) If a person is seeking an individual health benefit plan due to his or her having coverage under a conversion contract discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility under the conversion contract will be discontinued and the effective date of the individual coverage applied for is the date eligibility under the conversion contract will be discontinued, or within ninety days thereafter.

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

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

(b) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the person's application for enrollment to both the person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible

1 for health insurance provided by the Washington state health insurance
2 pool, and shall include information about the Washington state health
3 insurance pool and an application for such coverage. If the carrier
4 does not provide or postmark such notice within fifteen business days,
5 the application is deemed approved.

6 (3) If the person applying for an individual health benefit plan:
7 (a) Does not qualify for coverage under the Washington state health
8 insurance pool based upon the results of the standard health
9 questionnaire; (b) does qualify for coverage under the Washington state
10 health insurance pool based upon the results of the standard health
11 questionnaire and the carrier elects to accept the person for
12 enrollment; or (c) is not required to complete the standard health
13 questionnaire designated under this chapter under subsection (1)(a) or
14 (b) of this section, the carrier shall accept the person for enrollment
15 if he or she resides within the carrier's service area and provide or
16 assure the provision of all covered services regardless of age, sex,
17 family structure, ethnicity, race, health condition, geographic
18 location, employment status, socioeconomic status, other condition or
19 situation, or the provisions of RCW 49.60.174(2). The commissioner may
20 grant a temporary exemption from this subsection if, upon application
21 by a health carrier, the commissioner finds that the clinical,
22 financial, or administrative capacity to serve existing enrollees will
23 be impaired if a health carrier is required to continue enrollment of
24 additional eligible individuals.

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

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

28 (1) All health carriers shall accept for enrollment any state
29 resident within the group to whom the plan is offered and within the
30 carrier's service area and provide or assure the provision of all
31 covered services regardless of age, sex, family structure, ethnicity,
32 race, health condition, geographic location, employment status,
33 socioeconomic status, other condition or situation, or the provisions
34 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
35 exemption from this subsection, if, upon application by a health
36 carrier the commissioner finds that the clinical, financial, or
37 administrative capacity to serve existing enrollees will be impaired if

a health carrier is required to continue enrollment of additional eligible individuals.

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

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

(a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

(c) A carrier discontinues offering a particular type of health benefit plan offered to groups of up to two hundred if: (i) The carrier provides notice to each covered group provided coverage of this

type of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll in any other plan currently being offered by the carrier in the applicable group market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage;

(d) A carrier discontinues offering all health coverage to groups of up to two hundred in the state and discontinues coverage under all existing group health benefit plans in the large or small group market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any group health coverage in this state in the group market involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

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

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

(6) Notwithstanding any other provision of this section, the guarantee of continuity of coverage applies to a group of one only if:

(a) The carrier offering the particular plan in which the group of one was enrolled on the day prior to the effective date of this act continues to offer small group plans; and (b) the person continues to qualify as a group of one under the criteria in place on the day prior to the effective date of this act.

Sec. 5. RCW 48.44.023 and 1995 c 265 s 16 are each amended to read as follows:

(1)((~~(a) A health care services contractor offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A contractor offering a health benefit plan that does not include benefits in the basic health plan shall clearly disclose these differences to the small employer in a brochure approved by the commissioner.~~

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

~~(2)~~)) A health care service contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer no more than one health benefit plan including a limited schedule of covered health care services.

(a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to

comply with: RCW 48.44.210, 48.44.212, 48.44.225, 48.44.240 through 48.44.245, 48.44.290 through 48.44.340, 48.44.344, 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health care service contractor must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health care service contractor offering the plan under subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. ((~~(4) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) However, adjustments for each small group health benefit plan may vary by up to plus or minus ten percentage points from the overall adjustment of the carrier's entire small group pool upon a showing by the carrier, certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool.

Variations of greater than ten percentage points from the overall adjustment of the carrier's entire small group pool must be approved by the commissioner.

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

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

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

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

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

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

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

((~~(6)~~)) (7) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 6. RCW 48.46.066 and 1995 c 265 s 18 are each amended to read as follows:

(1)((~~(a) A health maintenance organization offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be~~

~~delivered to an individual enrolled in the basic health plan. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A health maintenance organization offering a health benefit plan that does not include benefits in the basic health plan shall clearly disclose these differences to the small employer in a brochure approved by the commissioner.~~

~~(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees.~~

~~(2)~~)) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer no more than one health benefit plan including a limited schedule of covered health care services.

(a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to comply with: RCW 48.46.250, 48.46.272 through 48.46.290, 48.46.320, 48.46.350, 48.46.375, 48.46.440 through 48.46.460, 48.46.480, 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.565, 48.46.570, 48.46.575, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

(b) In offering the plan under this subsection, the health maintenance organization must offer the small employer the option of permitting every category of health care provider to provide health services or care for conditions covered by the plan pursuant to RCW 48.43.045(1).

(2) A health maintenance organization offering the plan under

subsection (1) of this section must also offer and actively market to the small employer at least one additional health benefit plan.

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

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

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

((~~(4) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state.~~)) However, adjustments for each small group health benefit plan may vary by up to plus or minus ten percentage points from the overall adjustment of the carrier's entire small group pool upon a showing by the carrier, certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than ten percentage points from the overall adjustment of the carrier's entire small group pool must be approved by the commissioner.

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

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

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

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

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

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

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

((~~(6)~~)) (7) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 7. RCW 48.21.143 and 1997 c 276 s 3 are each amended to read as follows:

The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All group disability insurance contracts and blanket disability insurance contracts providing health care services, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For group disability insurance contracts and blanket disability insurance contracts that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all group disability insurance contracts and blanket disability insurance contracts providing health care services, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the insurer from restricting patients to seeing only health care providers who have signed participating provider agreements with the insurer or an insuring entity under contract with the insurer.

(3) Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

(6) The insurer need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.

(7) This section does not apply to the health benefit plan that provides benefits identical to the schedule of services covered by the basic health plan((~~, as required by RCW 48.21.045~~)).

Sec. 8. RCW 48.21.250 and 1984 c 190 s 2 are each amended to read as follows:

Every insurer that issues policies providing group coverage for hospital or medical expense shall offer the policyholder an option to include a policy provision granting a person who becomes ineligible for coverage under the group policy, the right to continue the group benefits for a period of time and at a rate agreed upon. ((~~The policy provision shall provide that when such coverage terminates, the covered person may convert to a policy as provided in RCW 48.21.260.~~))

Sec. 9. RCW 48.43.038 and 2000 c 79 s 25 are each amended to read as follows:

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

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

(a) Nonpayment of premium;

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

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

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

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

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

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

1 (3) This section does not apply in the following cases:
2 (a) A carrier has zero enrollment on a product;
3 (b) A carrier is withdrawing from a service area or from a segment
4 of its service area because the carrier has demonstrated to the
5 commissioner that the carrier's clinical, financial, or administrative
6 capacity to serve enrollees would be exceeded;
7 (c) No sooner than the first day of the month following the
8 expiration of a one hundred eighty-day period beginning on March 23,
9 2000, a carrier discontinues offering a particular type of health
10 benefit plan offered in the individual market<u>, including conversion</u>
11 <u>contracts,</u> if: (i) The carrier provides notice to each covered
12 individual provided coverage of this type of such discontinuation at
13 least ninety days prior to the date of the discontinuation; (ii) the
14 carrier offers to each individual provided coverage of this type the
15 option, without being subject to the standard health questionnaire, to
16 enroll in any other individual health benefit plan currently being
17 offered by the carrier; and (iii) in exercising the option to
18 discontinue coverage of this type and in offering the option of
19 coverage under (c)(ii) of this subsection, the carrier acts uniformly
20 without regard to any health status-related factor of enrolled
21 individuals or individuals who may become eligible for such coverage;
22 or
23 (d) A carrier discontinues offering all individual health coverage
24 in the state and discontinues coverage under all existing individual
25 health benefit plans if: (i) The carrier provides notice to the
26 commissioner of its intent to discontinue offering all individual
27 health coverage in the state and its intent to discontinue coverage
28 under all existing health benefit plans at least one hundred eighty
29 days prior to the date of the discontinuation of coverage under all
30 existing health benefit plans; and (ii) the carrier provides notice to
31 each covered individual of the intent to discontinue his or her
32 existing health benefit plan at least one hundred eighty days prior to
33 the date of such discontinuation. In the case of discontinuation under
34 this subsection, the carrier may not issue any individual health
35 coverage in this state for a five-year period beginning on the date of
36 the discontinuation of the last health plan not so renewed. Nothing in
37 this subsection (3) shall be construed to require a carrier to provide
38 notice to the commissioner of its intent to discontinue offering a

1 health benefit plan to new applicants where the carrier does not
2 discontinue coverage of existing enrollees under that health benefit
3 plan.
4 (4) The provisions of this section do not apply to health plans
5 deemed by the commissioner to be unique or limited or have a short-term
6 purpose, after a written request for such classification by the carrier
7 and subsequent written approval by the commissioner.

8 **Sec. 10.** RCW 48.44.315 and 1997 c 276 s 4 are each amended to read
9 as follows:
10 The legislature finds that diabetes imposes a significant health
11 risk and tremendous financial burden on the citizens and government of
12 the state of Washington, and that access to the medically accepted
13 standards of care for diabetes, its treatment and supplies, and self-
14 management training and education is crucial to prevent or delay the
15 short and long-term complications of diabetes and its attendant costs.
16 (1) The definitions in this subsection apply throughout this
17 section unless the context clearly requires otherwise.
18 (a) "Person with diabetes" means a person diagnosed by a health
19 care provider as having insulin using diabetes, noninsulin using
20 diabetes, or elevated blood glucose levels induced by pregnancy; and
21 (b) "Health care provider" means a health care provider as defined
22 in RCW 48.43.005.
23 (2) All health benefit plans offered by health care service
24 contractors, issued or renewed after January 1, 1998, shall provide
25 benefits for at least the following services and supplies for persons
26 with diabetes:
27 (a) For health benefit plans that include coverage for pharmacy
28 services, appropriate and medically necessary equipment and supplies,
29 as prescribed by a health care provider, that includes but is not
30 limited to insulin, syringes, injection aids, blood glucose monitors,
31 test strips for blood glucose monitors, visual reading and urine test
32 strips, insulin pumps and accessories to the pumps, insulin infusion
33 devices, prescriptive oral agents for controlling blood sugar levels,
34 foot care appliances for prevention of complications associated with
35 diabetes, and glucagon emergency kits; and
36 (b) For all health benefit plans, outpatient self-management
37 training and education, including medical nutrition therapy, as ordered
38 by the health care provider. Diabetes outpatient self-management

training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health care services contractor from restricting patients to seeing only health care providers who have signed participating provider agreements with the health care services contractor or an insuring entity under contract with the health care services contractor.

(3) Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

(6) The health care service contractor need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.

(7) This section does not apply to the health benefit plans that provide benefits identical to the schedule of services covered by the basic health plan((~~, as required by RCW 48.44.022 and 48.44.023~~)).

Sec. 11. RCW 48.44.360 and 1984 c 190 s 5 are each amended to read as follows:

Every health care service contractor that issues group contracts providing group coverage for hospital or medical expense shall offer the contract holder an option to include a contract provision granting a person who becomes ineligible for coverage under the group contract, the right to continue the group benefits for a period of time and at a rate agreed upon. ((~~The contract provision shall provide that when such coverage terminates, the covered person may convert to a contract as provided in RCW 48.44.370.~~))

Sec. 12. RCW 48.46.272 and 1997 c 276 s 5 are each amended to read as follows:

The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of

the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All health benefit plans offered by health maintenance organizations, issued or renewed after January 1, 1998, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For health benefit plans that include coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all health benefit plans, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents the health maintenance organization from restricting patients to seeing only health care providers who have signed participating provider agreements with the health maintenance organization or an insuring entity under contract with the health maintenance organization.

(3) Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

(6) The health maintenance organization need not include the coverage required in this section in a group contract offered to an employer or other group that offers to its eligible enrollees a self-insured health plan not subject to mandated benefits status under this title that does not offer coverage similar to that mandated under this section.

(7) This section does not apply to the health benefit plans that provide benefits identical to the schedule of services covered by the basic health plan((~~, as required by RCW 48.46.064 and 48.46.066~~)).

Sec. 13. RCW 48.46.440 and 1984 c 190 s 8 are each amended to read as follows:

Every health maintenance organization that issues agreements providing group coverage for hospital or medical care shall offer the agreement holder an option to include an agreement provision granting a person who becomes ineligible for coverage under the group agreement, the right to continue the group benefits for a period of time and at a rate agreed upon. ((~~The agreement provision shall provide that when such coverage terminates the covered person may convert to an agreement as provided in RCW 48.46.450.~~))

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

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

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

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

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

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

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

1 NEW SECTION. **Sec. 15.** This act applies to all group health
2 benefit plans issued or renewed on or after the effective date of this
3 act."

ESHB 2460 - S AMD **760**
By Senator Deccio

ADOPTED 03/03/2004

4 On page 1, line 2 of the title, after "employees;" strike the
5 remainder of the title and insert "amending RCW 48.21.045, 48.43.018,
6 48.43.035, 48.44.023, 48.46.066, 48.21.143, 48.21.250, 48.43.038,
7 48.44.315, 48.44.360, 48.46.272, and 48.46.440; reenacting and amending
8 RCW 48.43.005; creating a new section; and repealing RCW 48.21.260,
9 48.21.270, 48.44.370, 48.44.380, 48.46.450, and 48.46.460."

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