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**SUBSTITUTE HOUSE BILL 2460**

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**State of Washington**

**58th Legislature**

**2004 Regular Session**

**By** House Committee on Health Care (originally sponsored by Representatives Cody, Campbell, Kessler, Morrell, Haigh, Kenney, Santos, Hatfield, Blake, Linville, Upthegrove, Simpson, G., Moeller and Lantz)

READ FIRST TIME 02/06/04.

1       AN ACT Relating to access to health insurance for small employers  
2 and their employees; amending RCW 48.21.045, 48.43.018, 48.43.035,  
3 48.44.022, 48.44.023, 48.46.064, and 48.46.066; reenacting and amending  
4 RCW 48.43.005; adding a new section to chapter 48.43 RCW; and creating  
5 a new section.

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

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

9       (1)(a) An insurer offering any health benefit plan to a small  
10 employer shall offer and actively market to the small employer a health  
11 benefit plan (~~(providing benefits identical to the schedule of covered~~  
12 ~~health services that are required to be delivered to an individual~~  
13 ~~enrolled in the basic health plan)) featuring a limited schedule of  
14 covered health care services. Nothing in this subsection shall  
15 preclude an insurer from offering, or a small employer from purchasing,  
16 other health benefit plans that may have more (~~or less~~) comprehensive  
17 benefits than (~~the basic health plan, provided such plans are in~~  
18 ~~accordance with this chapter~~) those included in the product offered  
19 under this subsection. An insurer offering a health benefit plan~~

1 (~~that does not include benefits in the basic health plan~~) under this  
2 subsection shall clearly disclose (~~these differences~~) all covered  
3 benefits to the small employer in a brochure approved by the  
4 commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (i) Adjusted community rates established under this section shall  
31 pool the medical experience of all small groups purchasing coverage.  
32 Upon renewal, adjusted community rates for each small group health  
33 benefit plan may vary, at the carrier's discretion, by up to ten  
34 percentage points from the standard rate adjustment of the carrier's  
35 entire small group pool. During a renewal year, the weighted average  
36 of the adjustments shall have a revenue neutral effect on the carrier's  
37 small group pool.

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

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

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

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

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

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

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

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

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

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

1 Unless otherwise specifically provided, the definitions in this  
2 section apply throughout this chapter.

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

7 (2) "Basic health plan" means the plan described under chapter  
8 70.47 RCW, as revised from time to time.

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

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

15 (5) "Catastrophic health plan" means:

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

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

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

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

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

3 (8) "Covered person" or "enrollee" means a person covered by a  
4 health plan including an enrollee, subscriber, policyholder,  
5 beneficiary of a group plan, or individual covered by any other health  
6 plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (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



1 in RCW 48.46.020, and entities affiliated with, under contract with, or  
2 acting on behalf of a health carrier to perform a utilization review.

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

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

37 (26) "Wellness activity" means an explicit program of an activity  
38 consistent with department of health guidelines, such as, smoking

1 cessation, injury and accident prevention, reduction of alcohol misuse,  
2 appropriate weight reduction, exercise, automobile and motorcycle  
3 safety, blood cholesterol reduction, and nutrition education for the  
4 purpose of improving enrollee health status and reducing health service  
5 costs.

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

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

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

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

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

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

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

31 (c) If a person is seeking an individual health benefit plan due to  
32 his or her having exhausted continuation coverage provided under 29  
33 U.S.C. Sec. 1161 et seq., or is part of a group of less than twenty,  
34 and meets the same standards for continuation coverage, completion of  
35 the standard health questionnaire shall not be a condition of coverage  
36 if application for coverage is made within ninety days of exhaustion of  
37 continuation coverage. A health carrier shall accept an application

1 without a standard health questionnaire from a person currently covered  
2 by such continuation coverage if application is made within ninety days  
3 prior to the date the continuation coverage would be exhausted and the  
4 effective date of the individual coverage applied for is the date the  
5 continuation coverage would be exhausted, or within ninety days  
6 thereafter.

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

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

12 (b) Within fifteen business days of receipt of a completed  
13 application, the carrier shall provide written notice of the decision  
14 not to accept the person's application for enrollment to both the  
15 person and the administrator of the Washington state health insurance  
16 pool. The notice to the person shall state that the person is eligible  
17 for health insurance provided by the Washington state health insurance  
18 pool, and shall include information about the Washington state health  
19 insurance pool and an application for such coverage. If the carrier  
20 does not provide or postmark such notice within fifteen business days,  
21 the application is deemed approved.

22 (3) If the person applying for an individual health benefit plan:  
23 (a) Does not qualify for coverage under the Washington state health  
24 insurance pool based upon the results of the standard health  
25 questionnaire; (b) does qualify for coverage under the Washington state  
26 health insurance pool based upon the results of the standard health  
27 questionnaire and the carrier elects to accept the person for  
28 enrollment; or (c) is not required to complete the standard health  
29 questionnaire designated under this chapter under subsection (1)(a) or  
30 (b) of this section, the carrier shall accept the person for enrollment  
31 if he or she resides within the carrier's service area and provide or  
32 assure the provision of all covered services regardless of age, sex,  
33 family structure, ethnicity, race, health condition, geographic  
34 location, employment status, socioeconomic status, other condition or  
35 situation, or the provisions of RCW 49.60.174(2). The commissioner may  
36 grant a temporary exemption from this subsection if, upon application  
37 by a health carrier, the commissioner finds that the clinical,

1 financial, or administrative capacity to serve existing enrollees will  
2 be impaired if a health carrier is required to continue enrollment of  
3 additional eligible individuals.

4 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW  
5 to read as follows:

6 Any carrier offering health benefit plans to small employers under  
7 the provisions of RCW 48.21.045, 48.44.023, or 48.46.066 must offer and  
8 actively market to small employers at least three other plans of the  
9 carrier's choosing. However, this requirement does not apply to newly  
10 admitted carriers who offer a health benefit plan to small employers  
11 under the provisions of RCW 48.21.045, 48.44.023, or 48.46.066. This  
12 section does not limit the ability of a carrier to offer small employer  
13 group health benefit plans subject to all requirements applicable to  
14 health benefit plans offered under this chapter in addition to those  
15 that must be offered through the provisions of RCW 48.21.045,  
16 48.44.023, or 48.46.066.

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

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

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

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

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

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

7 (a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

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

1 and (iii) in exercising the option to discontinue coverage of this type  
2 and in offering the option of coverage under (c)(ii) of this  
3 subsection, the carrier acts uniformly without regard to any health  
4 status-related factor of enrolled individuals or individuals who may  
5 become eligible for this coverage;

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

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

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

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

37 (a) The carrier continues to offer any other small group plan in which  
38 the group of one was eligible to enroll in on the day prior to the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (2) Adjusted community rates established under this section shall  
13 pool the medical experience of all individuals purchasing coverage, and  
14 shall not be required to be pooled with the medical experience of  
15 health benefit plans offered to small employers under RCW 48.44.023.

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

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

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

36 (b) A health benefit plan offered under this subsection shall  
37 provide coverage for hospital expenses and services rendered by a



1 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
2 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245,  
3 (~~48.44.290, 48.44.300,~~) 48.44.310, 48.44.320, (~~48.44.325, 48.44.330,~~  
4 ~~48.44.335,~~) 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440,  
5 48.44.450, and 48.44.460 (~~(if: (i) The health benefit plan is the~~  
6 ~~mandatory offering under (a) of this subsection that provides benefits~~  
7 ~~identical to the basic health plan, to the extent these requirements~~  
8 ~~differ from the basic health plan; or (ii) the health benefit plan is~~  
9 ~~offered to)~~) for employers with not more than (~~(twenty-five))~~ fifty  
10 employees.

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

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

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

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

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

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

35 (d) The permitted rates for any age group shall be no more than  
36 four hundred twenty-five percent of the lowest rate for all age groups  
37 on January 1, 1996, four hundred percent on January 1, 1997, and three  
38 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. This  
21 subsection does not restrict or enhance the portability of benefits as  
22 provided in RCW 48.43.015.

23 (i) Adjusted community rates established under this section shall  
24 pool the medical experience of all groups purchasing coverage. Upon  
25 renewal, adjusted community rates for each small group health benefit  
26 plan may vary, at the carrier's discretion, by up to ten percentage  
27 points from the standard rate adjustment of the carrier's entire small  
28 group pool. During a renewal year, the weighted average of the  
29 adjustments shall have a revenue neutral effect on the carrier's small  
30 group pool.

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

37 (5)(a) Except as provided in this subsection, requirements used by

1 a contractor in determining whether to provide coverage to a small  
2 employer shall be applied uniformly among all small employers applying  
3 for coverage or receiving coverage from the carrier.

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

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

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

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

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

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

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

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

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

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

36 (i) Geographic area;

37 (ii) Family size;

1 (iii) Age;

2 (iv) Tenure discounts; and

3 (v) Wellness activities.

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

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

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

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

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

23 (i) Changes to the family composition;

24 (ii) Changes to the health benefit plan requested by the  
25 individual; or

26 (iii) Changes in government requirements affecting the health  
27 benefit plan.

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

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

37 (2) Adjusted community rates established under this section shall

1 pool the medical experience of all individuals purchasing coverage, and  
2 shall not be required to be pooled with the medical experience of  
3 health benefit plans offered to small employers under RCW 48.46.066.

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

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

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

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

36 (2) Nothing in this section shall prohibit a health maintenance  
37 organization from offering, or a purchaser from seeking, health benefit

1 plans with benefits in excess of the (~~basic health plan services~~)  
2 health benefit plan offered under subsection (1) of this section. All  
3 forms, policies, and contracts shall be submitted for approval to the  
4 commissioner, and the rates of any plan offered under this section  
5 shall be reasonable in relation to the benefits thereto.

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

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

- 11 (i) Geographic area;
- 12 (ii) Family size;
- 13 (iii) Age; and
- 14 (iv) Wellness activities.

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

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

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

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

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

- 34 (i) Changes to the enrollment of the small employer;
- 35 (ii) Changes to the family composition of the employee;
- 36 (iii) Changes to the health benefit plan requested by the small  
37 employer; or

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

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

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

13 (i) Adjusted community rates established under this section shall  
14 pool the medical experience of all groups purchasing coverage. Upon  
15 renewal, adjusted community rates for each small group health benefit  
16 plan may vary, at the carrier's discretion, by up to ten percentage  
17 points from the standard rate adjustment of the carrier's entire small  
18 group pool. During a renewal year, the weighted average of the  
19 adjustments shall have a revenue neutral effect on the carrier's small  
20 group pool.

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

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

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

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

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

37 (c) In applying minimum participation requirements with respect to

1 a small employer, a small employer shall not consider employees or  
2 dependents who have similar existing coverage in determining whether  
3 the applicable percentage of participation is met.

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

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

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

21 NEW SECTION. Sec. 10. Sections 1 through 4 and 6 through 11 of  
22 this act apply to all small group health benefit plans issued or  
23 renewed on or after the effective date of this section.

--- END ---