

CERTIFICATION OF ENROLLMENT
ENGROSSED SUBSTITUTE HOUSE BILL 2460

Chapter 244, Laws of 2004

(partial veto)

58th Legislature
2004 Regular Session

HEALTH INSURANCE--SMALL EMPLOYERS

EFFECTIVE DATE: 6/10/04

Passed by the House March 11, 2004
Yeas 89 Nays 7

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 11, 2004
Yeas 46 Nays 3

BRAD OWEN

President of the Senate

Approved March 31, 2004, with the
exception of sections 5, 11, 13, 15 and
16, which are vetoed.

GARY F. LOCKE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk
of the House of Representatives of
the State of Washington, do hereby
certify that the attached is
**ENGROSSED SUBSTITUTE HOUSE BILL
2460** as passed by the House of
Representatives and the Senate on
the dates hereon set forth.

RICHARD NAFZIGER

Chief Clerk

FILED

March 31, 2004 - 2:40 p.m.

**Secretary of State
State of Washington**

ENGROSSED SUBSTITUTE HOUSE BILL 2460

AS AMENDED BY THE SENATE

Passed Legislature - 2004 Regular Session

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 48.43.038, 48.44.022, 48.44.023, 48.46.064, 48.46.066, 48.21.143,
4 48.21.250, 48.44.315, 48.44.360, 48.46.272, and 48.46.440; reenacting
5 and amending RCW 48.43.005; creating a new section; and repealing RCW
6 48.21.260, 48.21.270, 48.44.370, 48.44.380, 48.46.450, and 48.46.460.

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

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

10 (1)(a) An insurer offering any health benefit plan to a small
11 employer (~~shall~~), either directly or through an association or
12 member-governed group formed specifically for the purpose of purchasing
13 health care, may offer and actively market to the small employer a
14 health benefit plan (~~providing benefits identical to the schedule of~~
15 ~~covered health services that are required to be delivered to an~~
16 ~~individual enrolled in the basic health plan~~) featuring a limited
17 schedule of covered health care services. Nothing in this subsection
18 shall preclude an insurer from offering, or a small employer from
19 purchasing, other health benefit plans that may have more (~~or less~~)

1 comprehensive benefits than (~~the basic health plan, provided such~~
2 ~~plans are in accordance with this chapter~~) those included in the
3 product offered under this subsection. An insurer offering a health
4 benefit plan (~~that does not include benefits in the basic health~~
5 ~~plan~~) under this subsection shall clearly disclose (~~these~~
6 ~~differences~~) all covered benefits to the small employer in a brochure
7 (~~approved by~~) filed with the commissioner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 (h) For the purposes of this section, a health benefit plan that
26 contains a restricted network provision shall not be considered similar
27 coverage to a health benefit plan that does not contain such a
28 provision, provided that the restrictions of benefits to network
29 providers result in substantial differences in claims costs. A carrier
30 may develop its rates based on claims costs due to network provider
31 reimbursement schedules or type of network. This subsection does not
32 restrict or enhance the portability of benefits as provided in RCW
33 48.43.015.

34 (i) Adjusted community rates established under this section shall
35 pool the medical experience of all small groups purchasing coverage.
36 However, annual rate adjustments for each small group health benefit
37 plan may vary by up to plus or minus four percentage points from the
38 overall adjustment of a carrier's entire small group pool, such overall

1 adjustment to be approved by the commissioner, upon a showing by the
2 carrier, certified by a member of the American academy of actuaries
3 that: (i) The variation is a result of deductible leverage, benefit
4 design, or provider network characteristics; and (ii) for a rate
5 renewal period, the projected weighted average of all small group
6 benefit plans will have a revenue neutral effect on the carrier's small
7 group pool. Variations of greater than four percentage points are
8 subject to review by the commissioner, and must be approved or denied
9 within sixty days of submittal. A variation that is not denied within
10 sixty days shall be deemed approved. The commissioner must provide to
11 the carrier a detailed actuarial justification for any denial within
12 thirty days of the denial.

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

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

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

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

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

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

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

37 (6) An insurer must offer coverage to all eligible employees of a
38 small employer and their dependents. An insurer may not offer coverage

1 to only certain individuals or dependents in a small employer group or
2 to only part of the group. An insurer may not modify a health plan
3 with respect to a small employer or any eligible employee or dependent,
4 through riders, endorsements or otherwise, to restrict or exclude
5 coverage or benefits for specific diseases, medical conditions, or
6 services otherwise covered by the plan.

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

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

12 Unless otherwise specifically provided, the definitions in this
13 section apply throughout this chapter.

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

18 (2) "Basic health plan" means the plan described under chapter
19 70.47 RCW, as revised from time to time.

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

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

26 (5) "Catastrophic health plan" means:

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

33 (b) In the case of a contract, agreement, or policy covering more
34 than one enrollee, a health benefit plan requiring a calendar year
35 deductible of, at a minimum, three thousand dollars and an annual out-
36 of-pocket expense required to be paid under the plan (other than for

1 premiums) for covered benefits of at least five thousand five hundred
2 dollars; or

3 (c) Any health benefit plan that provides benefits for hospital
4 inpatient and outpatient services, professional and prescription drugs
5 provided in conjunction with such hospital inpatient and outpatient
6 services, and excludes or substantially limits outpatient physician
7 services and those services usually provided in an office setting.

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

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

16 (8) "Covered person" or "enrollee" means a person covered by a
17 health plan including an enrollee, subscriber, policyholder,
18 beneficiary of a group plan, or individual covered by any other health
19 plan.

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

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

37 (11) "Emergency medical condition" means the emergent and acute
38 onset of a symptom or symptoms, including severe pain, that would lead

1 a prudent layperson acting reasonably to believe that a health
2 condition exists that requires immediate medical attention, if failure
3 to provide medical attention would result in serious impairment to
4 bodily functions or serious dysfunction of a bodily organ or part, or
5 would place the person's health in serious jeopardy.

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

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

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

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

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

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

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

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

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

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

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

14 (b) Medicare supplemental health insurance governed by chapter
15 48.66 RCW;

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

18 (d) Disability income;

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

22 (f) Workers' compensation coverage;

23 (g) Accident only coverage;

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

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

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

28 (k) Plans deemed by the insurance commissioner to have a short-term
29 limited purpose or duration, or to be a student-only plan that is
30 guaranteed renewable while the covered person is enrolled as a regular
31 full-time undergraduate or graduate student at an accredited higher
32 education institution, after a written request for such classification
33 by the carrier and subsequent written approval by the insurance
34 commissioner.

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

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

4 (22) "Premium" means all sums charged, received, or deposited by a
5 health carrier as consideration for a health plan or the continuance of
6 a health plan. Any assessment or any "membership," "policy,"
7 "contract," "service," or similar fee or charge made by a health
8 carrier in consideration for a health plan is deemed part of the
9 premium. "Premium" shall not include amounts paid as enrollee point-
10 of-service cost-sharing.

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

16 (24) "Small employer" or "small group" means any person, firm,
17 corporation, partnership, association, political subdivision, sole
18 proprietor, or self-employed individual that is actively engaged in
19 business that, on at least fifty percent of its working days during the
20 preceding calendar quarter, employed at least two but no more than
21 fifty eligible employees, with a normal work week of thirty or more
22 hours, the majority of whom were employed within this state, and is not
23 formed primarily for purposes of buying health insurance and in which
24 a bona fide employer-employee relationship exists. In determining the
25 number of eligible employees, companies that are affiliated companies,
26 or that are eligible to file a combined tax return for purposes of
27 taxation by this state, shall be considered an employer. Subsequent to
28 the issuance of a health plan to a small employer and for the purpose
29 of determining eligibility, the size of a small employer shall be
30 determined annually. Except as otherwise specifically provided, a
31 small employer shall continue to be considered a small employer until
32 the plan anniversary following the date the small employer no longer
33 meets the requirements of this definition. (~~The term "small employer"~~
34 ~~includes a self-employed individual or sole proprietor. The term~~
35 ~~"small employer" also includes~~) A self-employed individual or sole
36 proprietor (~~who derives~~) must derive at least seventy-five percent of
37 his or her income from a trade or business through which the individual
38 or sole proprietor has attempted to earn taxable income and for which

1 he or she has filed the appropriate internal revenue service form 1040,
2 schedule C or F, for the previous taxable year except for a self-
3 employed individual or sole proprietor in an agricultural trade or
4 business, who must derive at least fifty-one percent of his or her
5 income from the trade or business through which the individual or sole
6 proprietor has attempted to earn taxable income and for which he or she
7 has filed the appropriate internal revenue service form 1040, for the
8 previous taxable year. A self-employed individual or sole proprietor
9 who is covered as a group of one on the day prior to the effective date
10 of this section shall also be considered a "small employer" to the
11 extent that individual or group of one is entitled to have his or her
12 coverage renewed as provided in RCW 48.43.035(6).

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

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

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

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

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

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

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

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

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

13 (c) If a person is seeking an individual health benefit plan due to
14 his or her having exhausted continuation coverage provided under 29
15 U.S.C. Sec. 1161 et seq., 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 exhaustion of continuation
18 coverage. A health carrier shall accept an application without a
19 standard health questionnaire from a person currently covered by such
20 continuation coverage if application is made within ninety days prior
21 to the date the continuation coverage would be exhausted and the
22 effective date of the individual coverage applied for is the date the
23 continuation coverage would be exhausted, or within ninety days
24 thereafter.

25 (d) If a person is seeking an individual health benefit plan due to
26 his or her receiving notice that his or her coverage under a conversion
27 contract is discontinued, completion of the standard health
28 questionnaire shall not be a condition of coverage if application for
29 coverage is made within ninety days of discontinuation of eligibility
30 under the conversion contract. A health carrier shall accept an
31 application without a standard health questionnaire from a person
32 currently covered by such conversion contract if application is made
33 within ninety days prior to the date eligibility under the conversion
34 contract would be discontinued and the effective date of the individual
35 coverage applied for is the date eligibility under the conversion
36 contract would be discontinued, or within ninety days thereafter.

37 (e) If a person is seeking an individual health benefit plan and,
38 but for the number of persons employed by his or her employer, would

1 have qualified for continuation coverage provided under 29 U.S.C. Sec.
2 1161 et seq., completion of the standard health questionnaire shall not
3 be a condition of coverage if: (i) Application for coverage is made
4 within ninety days of a qualifying event as defined in 29 U.S.C. Sec.
5 1163; and (ii) the person had at least twenty-four months of continuous
6 group coverage immediately prior to the qualifying event. A health
7 carrier shall accept an application without a standard health
8 questionnaire from a person with at least twenty-four months of
9 continuous group coverage if application is made no more than ninety
10 days prior to the date of a qualifying event and the effective date of
11 the individual coverage applied for is the date of the qualifying
12 event, or within ninety days thereafter.

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

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

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

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

29 (a) Does not qualify for coverage under the Washington state health
30 insurance pool based upon the results of the standard health
31 questionnaire; (b) does qualify for coverage under the Washington state
32 health insurance pool based upon the results of the standard health
33 questionnaire and the carrier elects to accept the person for
34 enrollment; or (c) is not required to complete the standard health
35 questionnaire designated under this chapter under subsection (1)(a) or
36 (b) of this section, the carrier shall accept the person for enrollment
37 if he or she resides within the carrier's service area and provide or
38 assure the provision of all covered services regardless of age, sex,

1 family structure, ethnicity, race, health condition, geographic
2 location, employment status, socioeconomic status, other condition or
3 situation, or the provisions of RCW 49.60.174(2). The commissioner may
4 grant a temporary exemption from this subsection if, upon application
5 by a health carrier, the commissioner finds that the clinical,
6 financial, or administrative capacity to serve existing enrollees will
7 be impaired if a health carrier is required to continue enrollment of
8 additional eligible individuals.

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

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

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

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

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

35 (a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

21 (c) No sooner than January 1, 2005, a carrier discontinues offering
22 a particular type of health benefit plan offered for groups of up to
23 two hundred if: (i) The carrier provides notice to each group of the
24 discontinuation at least ninety days prior to the date of the
25 discontinuation; (ii) the carrier offers to each group provided
26 coverage of this type the option to enroll, with regard to small
27 employer groups, in any other small employer group plan, or with regard
28 to groups of up to two hundred, in any other applicable group plan,
29 currently being offered by the carrier in the applicable group market;
30 and (iii) in exercising the option to discontinue coverage of this type
31 and in offering the option of coverage under (c)(ii) of this
32 subsection, the carrier acts uniformly without regard to any health
33 status-related factor of enrolled individuals or individuals who may
34 become eligible for this coverage;

35 (d) A carrier discontinues offering all health coverage in the
36 small group market or for groups of up to two hundred, or both markets,
37 in the state and discontinues coverage under all existing group health
38 benefit plans in the applicable market involved if: (i) The carrier

1 provides notice to the commissioner of its intent to discontinue
2 offering all such coverage in the state and its intent to discontinue
3 coverage under all such existing health benefit plans at least one
4 hundred eighty days prior to the date of the discontinuation of
5 coverage under all such existing health benefit plans; and (ii) the
6 carrier provides notice to each covered group of the intent to
7 discontinue the existing health benefit plan at least one hundred
8 eighty days prior to the date of discontinuation. In the case of
9 discontinuation under this subsection, the carrier may not issue any
10 group health coverage in this state in the applicable group market
11 involved for a five-year period beginning on the date of the
12 discontinuation of the last health benefit plan not so renewed. This
13 subsection (4) does not require a carrier to provide notice to the
14 commissioner of its intent to discontinue offering a health benefit
15 plan to new applicants when the carrier does not discontinue coverage
16 of existing enrollees under that health benefit plan; or

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

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

26 (6) Notwithstanding any other provision of this section, the
27 guarantee of continuity of coverage applies to a group of one only if:
28 (a) The carrier continues to offer any other small employer group plan
29 in which the group of one was eligible to enroll on the day prior to
30 the effective date of this section; and (b) the person continues to
31 qualify as a group of one under the criteria in place on the day prior
32 to the effective date of this section.

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

35 **(1) Except as provided in subsection (4) of this section, all**
36 **individual health plans shall contain or incorporate by endorsement a**
37 **guarantee of the continuity of coverage of the plan. For the purposes**

1 of this section, a plan is "renewed" when it is continued beyond the
2 earliest date upon which, at the carrier's sole option, the plan could
3 have been terminated for other than nonpayment of premium.

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

7 (a) Nonpayment of premium;

8 (b) Violation of published policies of the carrier approved by the
9 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 (3) This section does not apply in the following cases:

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

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

27 (c) No sooner than the first day of the month following the
28 expiration of a one hundred eighty-day period beginning on March 23,
29 2000, a carrier discontinues offering a particular type of health
30 benefit plan offered in the individual market, including conversion
31 contracts, if: (i) The carrier provides notice to each covered
32 individual provided coverage of this type of such discontinuation at
33 least ninety days prior to the date of the discontinuation; (ii) the
34 carrier offers to each individual provided coverage of this type the
35 option, without being subject to the standard health questionnaire, to
36 enroll in any other individual health benefit plan currently being
37 offered by the carrier; and (iii) in exercising the option to
38 discontinue coverage of this type and in offering the option of

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

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

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

**Sec. 5 was vetoed. See message at end of chapter.*

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

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

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

35 (i) Geographic area;

36 (ii) Family size;

37 (iii) Age;

1 (iv) Tenure discounts; and

2 (v) Wellness activities.

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

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

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

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

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

22 (i) Changes to the family composition;

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

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

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

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

36 (2) Adjusted community rates established under this section shall
37 pool the medical experience of all individuals purchasing coverage, and

1 shall not be required to be pooled with the medical experience of
2 health benefit plans offered to small employers under RCW 48.44.023.

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

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

8 (1)(a) A health care services contractor offering any health
9 benefit plan to a small employer (~~shall~~), either directly or through
10 an association or member-governed group formed specifically for the
11 purpose of purchasing health care, may offer and actively market to the
12 small employer a health benefit plan (~~providing benefits identical to~~
13 ~~the schedule of covered health services that are required to be~~
14 ~~delivered to an individual enrolled in the basic health plan))~~
15 featuring a limited schedule of covered health care services. Nothing
16 in this subsection shall preclude a contractor from offering, or a
17 small employer from purchasing, other health benefit plans that may
18 have more (~~or less~~) comprehensive benefits than (~~the basic health~~
19 ~~plan, provided such plans are in accordance with this chapter)) those
20 included in the product offered under this subsection. A contractor
21 offering a health benefit plan (~~that does not include benefits in the~~
22 ~~basic health plan)) under this subsection shall clearly disclose
23 (~~these differences~~) all covered benefits to the small employer in a
24 brochure (~~approved by~~) filed with 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 48.44.225, 48.44.240, 48.44.245, 48.44.290,
29 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,
30 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and
31 48.44.460 (~~if: (i) The health benefit plan is the mandatory offering~~
32 ~~under (a) of this subsection that provides benefits identical to the~~
33 ~~basic health plan, to the extent these requirements differ from the~~
34 ~~basic health plan; or (ii) the health benefit plan is offered to~~
35 ~~employers with not more than twenty five employees)).~~

36 (2) Nothing in this section shall prohibit a health care service
37 contractor 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 contractor shall develop its rates based on an adjusted
9 community rate and may only vary the adjusted community rate for:

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

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

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

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

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

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

- 33 (i) Changes to the enrollment of the small employer;
- 34 (ii) Changes to the family composition of the employee;
- 35 (iii) Changes to the health benefit plan requested by the small
36 employer; or
- 37 (iv) Changes in government requirements affecting the health
38 benefit plan.

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

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

13 (i) Adjusted community rates established under this section shall
14 pool the medical experience of all groups purchasing coverage.
15 However, annual rate adjustments for each small group health benefit
16 plan may vary by up to plus or minus four percentage points from the
17 overall adjustment of a carrier's entire small group pool, such overall
18 adjustment to be approved by the commissioner, upon a showing by the
19 carrier, certified by a member of the American academy of actuaries
20 that: (i) The variation is a result of deductible leverage, benefit
21 design, or provider network characteristics; and (ii) for a rate
22 renewal period, the projected weighted average of all small group
23 benefit plans will have a revenue neutral effect on the carrier's small
24 group pool. Variations of greater than four percentage points are
25 subject to review by the commissioner, and must be approved or denied
26 within sixty days of submittal. A variation that is not denied within
27 sixty days shall be deemed approved. The commissioner must provide to
28 the carrier a detailed actuarial justification for any denial within
29 thirty days of the denial.

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

36 (5)(a) Except as provided in this subsection, requirements used by
37 a contractor in determining whether to provide coverage to a small

1 employer shall be applied uniformly among all small employers applying
2 for coverage or receiving coverage from the carrier.

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

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

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

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

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

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

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

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

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

- 32 (i) Geographic area;
- 33 (ii) Family size;
- 34 (iii) Age;
- 35 (iv) Tenure discounts; and
- 36 (v) Wellness activities.

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

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

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

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

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

20 (i) Changes to the family composition;

21 (ii) Changes to the health benefit plan requested by the
22 individual; or

23 (iii) Changes in government requirements affecting the health
24 benefit plan.

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

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

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

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

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

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

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

34 (2) Nothing in this section shall prohibit a health maintenance
35 organization from offering, or a purchaser from seeking, health benefit
36 plans with benefits in excess of the (~~(basic health plan services))~~)
37 health benefit plan offered under subsection (1) of this section. All

1 forms, policies, and contracts shall be submitted for approval to the
2 commissioner, and the rates of any plan offered under this section
3 shall be reasonable in relation to the benefits thereto.

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

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

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

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

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

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

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

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

- 32 (i) Changes to the enrollment of the small employer;
- 33 (ii) Changes to the family composition of the employee;
- 34 (iii) Changes to the health benefit plan requested by the small
35 employer; or
- 36 (iv) Changes in government requirements affecting the health
37 benefit plan.

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

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

13 (i) Adjusted community rates established under this section shall
14 pool the medical experience of all groups purchasing coverage.
15 However, annual rate adjustments for each small group health benefit
16 plan may vary by up to plus or minus four percentage points from the
17 overall adjustment of a carrier's entire small group pool, such overall
18 adjustment to be approved by the commissioner, upon a showing by the
19 carrier, certified by a member of the American academy of actuaries
20 that: (i) The variation is a result of deductible leverage, benefit
21 design, or provider network characteristics; and (ii) for a rate
22 renewal period, the projected weighted average of all small group
23 benefit plans will have a revenue neutral effect on the carrier's small
24 group pool. Variations of greater than four percentage points are
25 subject to review by the commissioner, and must be approved or denied
26 within sixty days of submittal. A variation that is not denied within
27 sixty days shall be deemed approved. The commissioner must provide to
28 the carrier a detailed actuarial justification for any denial within
29 thirty days of the denial.

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

36 (5)(a) Except as provided in this subsection, requirements used by
37 a health maintenance organization in determining whether to provide

1 coverage to a small employer shall be applied uniformly among all small
2 employers applying for coverage or receiving coverage from the carrier.

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

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

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

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

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

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

27 **Sec. 10.** RCW 48.21.143 and 1997 c 276 s 3 are each amended to read
28 as follows:

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

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

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

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

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

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

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

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

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

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

37 (6) The insurer need not include the coverage required in this
38 section in a group contract offered to an employer or other group that

1 offers to its eligible enrollees a self-insured health plan not subject
2 to mandated benefits status under this title that does not offer
3 coverage similar to that mandated under this section.

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

7 ***Sec. 11. RCW 48.21.250 and 1984 c 190 s 2 are each amended to read**
8 **as follows:**

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

**Sec. 11 was vetoed. See message at end of chapter.*

16 **Sec. 12. RCW 48.44.315 and 1997 c 276 s 4 are each amended to read**
17 **as follows:**

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

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

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

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

31 (2) All health benefit plans offered by health care service
32 contractors, issued or renewed after January 1, 1998, shall provide
33 benefits for at least the following services and supplies for persons
34 with diabetes:

35 (a) For health benefit plans that include coverage for pharmacy
36 services, appropriate and medically necessary equipment and supplies,

1 as prescribed by a health care provider, that includes but is not
2 limited to insulin, syringes, injection aids, blood glucose monitors,
3 test strips for blood glucose monitors, visual reading and urine test
4 strips, insulin pumps and accessories to the pumps, insulin infusion
5 devices, prescriptive oral agents for controlling blood sugar levels,
6 foot care appliances for prevention of complications associated with
7 diabetes, and glucagon emergency kits; and

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

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

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

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

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

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

34 ***Sec. 13. RCW 48.44.360 and 1984 c 190 s 5 are each amended to read**
35 **as follows:**

36 **Every health care service contractor that issues group contracts**
37 **providing group coverage for hospital or medical expense shall offer**

1 *the contract holder an option to include a contract provision granting*
2 *a person who becomes ineligible for coverage under the group contract,*
3 *the right to continue the group benefits for a period of time and at a*
4 *rate agreed upon. ((The contract provision shall provide that when*
5 *such coverage terminates, the covered person may convert to a contract*
6 *as provided in RCW 48.44.370.))*

**Sec. 13 was vetoed. See message at end of chapter.*

7 **Sec. 14.** RCW 48.46.272 and 1997 c 276 s 5 are each amended to read
8 as follows:

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

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

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

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

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

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

35 (b) For all health benefit plans, outpatient self-management
36 training and education, including medical nutrition therapy, as ordered
37 by the health care provider. Diabetes outpatient self-management

1 training and education may be provided only by health care providers
2 with expertise in diabetes. Nothing in this section prevents the
3 health maintenance organization from restricting patients to seeing
4 only health care providers who have signed participating provider
5 agreements with the health maintenance organization or an insuring
6 entity under contract with the health maintenance organization.

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

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

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

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

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

24 ***Sec. 15. RCW 48.46.440 and 1984 c 190 s 8 are each amended to read**
25 **as follows:**

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

**Sec. 15 was vetoed. See message at end of chapter.*

34 ***NEW SECTION. Sec. 16. The following acts or parts of acts are**
35 **each repealed:**

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

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

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

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

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

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

*Sec. 16 was vetoed. See message at end of chapter.

13 NEW SECTION. **Sec. 17.** Sections 1 through 15 of this act apply to
14 all small group health benefit plans issued or renewed on or after the
15 effective date of this section.

Passed by the House March 11, 2004.

Passed by the Senate March 11, 2004.

Approved by the Governor March 31, 2004, with the exception of
certain items that were vetoed.

Filed in Office of Secretary of State March 31, 2004.

Note: Governor's explanation of partial veto is as follows:

"I am returning herewith, without my approval as to sections 5, 11,
13, 15 and 16, Engrossed Substitute House Bill No. 2460 entitled:

"AN ACT Relating to access to health insurance for small
employers and their employees;"

This bill provides changes that redefine the small group health
insurance market and requirements related to guaranteed renewal. It
also adds factors that may be considered in the development of rates,
and provides protections for those individuals not previously
protected by health benefit extensions in the Consolidated Omnibus
Budget Reconciliation Act (COBRA).

Section 16 would have repealed the requirement that carriers offer
conversion health plans to group enrollees who lose coverage in the
private insurance market. Under federal Health Insurance Portability
and Accountability Act (HIPAA) requirements, conversion health plans
must be issued, and must not impose restrictions relating to
preexisting conditions. Sections 5, 11, 13, and 15 would have
amended related statutes to ensure that they were consistent with the
repeal of conversion health plans. At the request of the prime
sponsor and Insurance Commissioner, I have vetoed these sections. If
these provisions had been repealed, Washington would have been unable
to certify that we have a functioning state alternative mechanism
that compiles with HIPAA.

For these reasons, I have vetoed sections 5, 11, 13, 15, and 16 of
Engrossed Substitute House Bill No. 2460.

With the exception of sections 5, 11, 13, 15, and 16, Engrossed Substitute House Bill No. 2460 is approved."