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SENATE BILL 5981

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State of Washington

59th Legislature

2005 Regular Session

By Senators Parlette, Deccio, Brandland and Schmidt

Read first time 02/17/2005. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to cost reduction in health benefit plans; amending  
2 RCW 48.21.045, 48.44.023, 48.46.066, and 41.05.065; and creating a new  
3 section.

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

5 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

6 (a) The cost of health care, along with the number of uninsured  
7 persons, is continuing to rise;

8 (b) Many individuals are uninsured because employers are not given  
9 adequate health insurance options that they and their employees can  
10 afford; and

11 (c) The purchaser and recipient of health care should have more  
12 control over the services and products they purchase.

13 (2) The legislature intends to provide employees with more options  
14 in choosing a quality health care plan that meets their individual  
15 needs.

16 **Sec. 2.** RCW 48.21.045 and 2004 c 244 s 1 are each amended to read  
17 as follows:

18 (1)(a) An insurer offering any health benefit plan to a small

1 employer, either directly or through an association or member-governed  
2 group formed specifically for the purpose of purchasing health care,  
3 may offer and actively market to the small employer a health benefit  
4 plan featuring a limited schedule of covered health care services.  
5 Nothing in this subsection shall preclude an insurer from offering, or  
6 a small employer from purchasing, other health benefit plans that may  
7 have more comprehensive benefits than those included in the product  
8 offered under this subsection. An insurer offering a health benefit  
9 plan under this subsection shall clearly disclose all covered benefits  
10 to the small employer in a brochure filed with the commissioner.

11 (b) A health benefit plan offered under this subsection shall  
12 provide coverage for hospital expenses and services rendered by a  
13 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
14 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,  
15 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,  
16 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244,  
17 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

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

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

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

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

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

37 (c) The insurer shall be permitted to develop separate rates for  
38 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.

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. A carrier  
28 may develop its rates based on claims costs (~~(due to network provider~~  
29 ~~reimbursement schedules or type of network)) for a plan. This  
30 subsection does not restrict or enhance the portability of benefits as  
31 provided in RCW 48.43.015.~~

32 (i) Except for small group health benefit plans that qualify as  
33 insurance coverage combined with a health savings account as defined by  
34 the United States internal revenue service, adjusted community rates  
35 established under this section shall pool the medical experience of all  
36 small groups purchasing coverage. However, annual rate adjustments for  
37 each small group health benefit plan may vary by up to plus or minus  
38 (~~four~~) eight percentage points from the overall adjustment of a

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

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

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

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

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

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

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

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

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

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

16 **Sec. 3.** RCW 48.44.023 and 2004 c 244 s 7 are each amended to read  
17 as follows:

18 (1)(a) A health care services contractor offering any health  
19 benefit plan to a small employer, either directly or through an  
20 association or member-governed group formed specifically for the  
21 purpose of purchasing health care, may offer and actively market to the  
22 small employer a health benefit plan featuring a limited schedule of  
23 covered health care services. Nothing in this subsection shall  
24 preclude a contractor from offering, or a small employer from  
25 purchasing, other health benefit plans that may have more comprehensive  
26 benefits than those included in the product offered under this  
27 subsection. A contractor offering a health benefit plan under this  
28 subsection shall clearly disclose all covered benefits to the small  
29 employer in a brochure filed with the commissioner.

30 (b) A health benefit plan offered under this subsection shall  
31 provide coverage for hospital expenses and services rendered by a  
32 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
33 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,  
34 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,  
35 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and  
36 48.44.460.

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

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

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

- 12 (i) Geographic area;
- 13 (ii) Family size;
- 14 (iii) Age; and
- 15 (iv) 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. Employees under the age  
19 of twenty shall be treated as those age twenty.

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

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.

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 enrollment of the small employer;
- 36 (ii) Changes to the family composition of the employee;
- 37 (iii) Changes to the health benefit plan requested by the small  
38 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. A carrier  
11 may develop its rates based on claims costs (~~(due to network provider~~  
12 ~~reimbursement schedules or type of network)) for a plan. This  
13 subsection does not restrict or enhance the portability of benefits as  
14 provided in RCW 48.43.015.~~

15 (i) Except for small group health benefit plans that qualify as  
16 insurance coverage combined with a health savings account as defined by  
17 the United States internal revenue service, adjusted community rates  
18 established under this section shall pool the medical experience of all  
19 groups purchasing coverage. However, annual rate adjustments for each  
20 small group health benefit plan may vary by up to plus or minus  
21 (~~four~~) eight percentage points from the overall adjustment of a  
22 carrier's entire small group pool(~~(, such overall adjustment to be~~  
23 ~~approved by the commissioner, upon a showing by the carrier, certified~~  
24 ~~by a member of the American academy of actuaries that: (i) The~~  
25 ~~variation is a result of deductible leverage, benefit design, or~~  
26 ~~provider network characteristics; and (ii) for a rate renewal period,~~  
27 ~~the projected weighted average of all small group benefit plans will~~  
28 ~~have a revenue neutral effect on the carrier's small group pool.~~  
29 ~~Variations of greater than four percentage points are subject to review~~  
30 ~~by the commissioner, and must be approved or denied within sixty days~~  
31 ~~of submittal)) if certified by a member of the American academy of  
32 actuaries, that: (i) The variation is a result of deductible leverage,  
33 benefit design, claims cost trend for the plan, or provider network  
34 characteristics; and (ii) for a rate renewal period, the projected  
35 weighted average of all small group benefit plans will have a revenue  
36 neutral effect on the carrier's small group pool. Variations of  
37 greater than eight percentage points are subject to review by the  
38 commissioner, and must be approved or denied within thirty days of~~

1 submittal. A variation that is not denied within (~~sixty~~) thirty days  
2 shall be deemed approved. The commissioner must provide to the carrier  
3 a detailed actuarial justification for any denial (~~within thirty~~  
4 ~~days~~) at the time of the denial.

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

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

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

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

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

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

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

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

34 **Sec. 4.** RCW 48.46.066 and 2004 c 244 s 9 are each amended to read  
35 as follows:

36 (1)(a) A health maintenance organization offering any health  
37 benefit plan to a small employer, either directly or through an

1 association or member-governed group formed specifically for the  
2 purpose of purchasing health care, may offer and actively market to the  
3 small employer a health benefit plan featuring a limited schedule of  
4 covered health care services. Nothing in this subsection shall  
5 preclude a health maintenance organization from offering, or a small  
6 employer from purchasing, other health benefit plans that may have more  
7 comprehensive benefits than those included in the product offered under  
8 this subsection. A health maintenance organization offering a health  
9 benefit plan under this subsection shall clearly disclose all the  
10 covered benefits to the small employer in a brochure filed with the  
11 commissioner.

12 (b) A health benefit plan offered under this subsection shall  
13 provide coverage for hospital expenses and services rendered by a  
14 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
15 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290,  
16 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510,  
17 48.46.520, and 48.46.530.

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

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

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

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

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

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

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)) for a plan. This  
32 subsection does not restrict or enhance the portability of benefits as  
33 provided in RCW 48.43.015.~~

34 (i) Except for small group health benefit plans that qualify as  
35 insurance coverage combined with a health savings account as defined by  
36 the United States internal revenue service, adjusted community rates  
37 established under this section shall pool the medical experience of all  
38 groups purchasing coverage. However, annual rate adjustments for each

1 small group health benefit plan may vary by up to plus or minus  
2 (~~four~~) eight percentage points from the overall adjustment of a  
3 carrier's entire small group pool(~~(, such overall adjustment to be~~  
4 ~~approved by the commissioner, upon a showing by the carrier, certified~~  
5 ~~by a member of the American academy of actuaries that: (i) The~~  
6 ~~variation is a result of deductible leverage, benefit design, or~~  
7 ~~provider network characteristics; and (ii) for a rate renewal period,~~  
8 ~~the projected weighted average of all small group benefit plans will~~  
9 ~~have a revenue neutral effect on the carrier's small group pool.~~  
10 ~~Variations of greater than four percentage points are subject to review~~  
11 ~~by the commissioner, and must be approved or denied within sixty days~~  
12 ~~of submittal)) if certified by a member of the American academy of  
13 actuaries, that: (i) The variation is a result of deductible leverage,  
14 benefit design, claims cost trend for the plan, or provider network  
15 characteristics; and (ii) for a rate renewal period, the projected  
16 weighted average of all small group benefit plans will have a revenue  
17 neutral effect on the health maintenance organization's small group  
18 pool. Variations of greater than eight percentage points are subject  
19 to review by the commissioner, and must be approved or denied within  
20 thirty days of submittal. A variation that is not denied within  
21 (~~sixty~~) thirty days shall be deemed approved. The commissioner must  
22 provide to the carrier a detailed actuarial justification for any  
23 denial (~~within thirty days~~) at the time of the denial.~~

24 (4) Nothing in this section shall restrict the right of employees  
25 to collectively bargain for insurance providing benefits in excess of  
26 those provided 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 **Sec. 5.** RCW 41.05.065 and 2003 c 158 s 2 are each amended to read  
19 as follows:

20 (1) The board shall study all matters connected with the provision  
21 of health care coverage, life insurance, liability insurance,  
22 accidental death and dismemberment insurance, and disability income  
23 insurance or any of, or a combination of, the enumerated types of  
24 insurance for employees and their dependents on the best basis possible  
25 with relation both to the welfare of the employees and to the state.  
26 However, liability insurance shall not be made available to dependents.

27 (2) The board shall develop employee benefit plans that include  
28 comprehensive health care benefits for all employees. In developing  
29 these plans, the board shall consider the following elements:

30 (a) Methods of maximizing cost containment while ensuring access to  
31 quality health care;

32 (b) Development of provider arrangements that encourage cost  
33 containment and ensure access to quality care, including but not  
34 limited to prepaid delivery systems and prospective payment methods;

35 (c) Wellness incentives that focus on proven strategies, such as  
36 smoking cessation, injury and accident prevention, reduction of alcohol

1 misuse, appropriate weight reduction, exercise, automobile and  
2 motorcycle safety, blood cholesterol reduction, and nutrition  
3 education;

4 (d) Utilization review procedures including, but not limited to a  
5 cost-efficient method for prior authorization of services, hospital  
6 inpatient length of stay review, requirements for use of outpatient  
7 surgeries and second opinions for surgeries, review of invoices or  
8 claims submitted by service providers, and performance audit of  
9 providers;

10 (e) Effective coordination of benefits;

11 (f) Minimum standards for insuring entities; and

12 (g) Minimum scope and content of public employee benefit plans to  
13 be offered to enrollees participating in the employee health benefit  
14 plans. To maintain the comprehensive nature of employee health care  
15 benefits, employee eligibility criteria related to the number of hours  
16 worked and the benefits provided to employees shall be substantially  
17 equivalent to the state employees' health benefits plan and eligibility  
18 criteria in effect on January 1, 1993. Nothing in this subsection  
19 (2)(g) shall prohibit changes or increases in employee point-of-service  
20 payments or employee premium payments for benefits.

21 (3) The board shall design benefits and determine the terms and  
22 conditions of employee participation and coverage, including  
23 establishment of eligibility criteria. The same terms and conditions  
24 of participation and coverage, including eligibility criteria, shall  
25 apply to state employees and to school district employees and  
26 educational service district employees.

27 (4) The board may authorize premium contributions for an employee  
28 and the employee's dependents in a manner that encourages the use of  
29 cost-efficient managed health care systems. The board shall require  
30 participating school district and educational service district  
31 employees to pay at least the same employee premiums by plan and family  
32 size as state employees pay.

33 (5) The board shall develop a health savings account option for  
34 employees that conforms to section 223, Part VII of subchapter B of  
35 chapter 1 of the internal revenue code of 1986. The board shall comply  
36 with all applicable federal standards related to the establishment of  
37 health savings accounts.

1        (6) Employees shall choose participation in one of the health care  
2 benefit plans developed by the board and may be permitted to waive  
3 coverage under terms and conditions established by the board.

4        ~~((+6+))~~ (7) The board shall review plans proposed by insuring  
5 entities that desire to offer property insurance and/or accident and  
6 casualty insurance to state employees through payroll deduction. The  
7 board may approve any such plan for payroll deduction by insuring  
8 entities holding a valid certificate of authority in the state of  
9 Washington and which the board determines to be in the best interests  
10 of employees and the state. The board shall promulgate rules setting  
11 forth criteria by which it shall evaluate the plans.

12        ~~((+7+))~~ (8) Before January 1, 1998, the public employees' benefits  
13 board shall make available one or more fully insured long-term care  
14 insurance plans that comply with the requirements of chapter 48.84 RCW.  
15 Such programs shall be made available to eligible employees, retired  
16 employees, and retired school employees as well as eligible dependents  
17 which, for the purpose of this section, includes the parents of the  
18 employee or retiree and the parents of the spouse of the employee or  
19 retiree. Employees of local governments and employees of political  
20 subdivisions not otherwise enrolled in the public employees' benefits  
21 board sponsored medical programs may enroll under terms and conditions  
22 established by the administrator, if it does not jeopardize the  
23 financial viability of the public employees' benefits board's long-term  
24 care offering.

25        (a) Participation of eligible employees or retired employees and  
26 retired school employees in any long-term care insurance plan made  
27 available by the public employees' benefits board is voluntary and  
28 shall not be subject to binding arbitration under chapter 41.56 RCW.  
29 Participation is subject to reasonable underwriting guidelines and  
30 eligibility rules established by the public employees' benefits board  
31 and the health care authority.

32        (b) The employee, retired employee, and retired school employee are  
33 solely responsible for the payment of the premium rates developed by  
34 the health care authority. The health care authority is authorized to  
35 charge a reasonable administrative fee in addition to the premium  
36 charged by the long-term care insurer, which shall include the health  
37 care authority's cost of administration, marketing, and consumer

1 education materials prepared by the health care authority and the  
2 office of the insurance commissioner.

3 (c) To the extent administratively possible, the state shall  
4 establish an automatic payroll or pension deduction system for the  
5 payment of the long-term care insurance premiums.

6 (d) The public employees' benefits board and the health care  
7 authority shall establish a technical advisory committee to provide  
8 advice in the development of the benefit design and establishment of  
9 underwriting guidelines and eligibility rules. The committee shall  
10 also advise the board and authority on effective and cost-effective  
11 ways to market and distribute the long-term care product. The  
12 technical advisory committee shall be comprised, at a minimum, of  
13 representatives of the office of the insurance commissioner, providers  
14 of long-term care services, licensed insurance agents with expertise in  
15 long-term care insurance, employees, retired employees, retired school  
16 employees, and other interested parties determined to be appropriate by  
17 the board.

18 (e) The health care authority shall offer employees, retired  
19 employees, and retired school employees the option of purchasing long-  
20 term care insurance through licensed agents or brokers appointed by the  
21 long-term care insurer. The authority, in consultation with the public  
22 employees' benefits board, shall establish marketing procedures and may  
23 consider all premium components as a part of the contract negotiations  
24 with the long-term care insurer.

25 (f) In developing the long-term care insurance benefit designs, the  
26 public employees' benefits board shall include an alternative plan of  
27 care benefit, including adult day services, as approved by the office  
28 of the insurance commissioner.

29 (g) The health care authority, with the cooperation of the office  
30 of the insurance commissioner, shall develop a consumer education  
31 program for the eligible employees, retired employees, and retired  
32 school employees designed to provide education on the potential need  
33 for long-term care, methods of financing long-term care, and the  
34 availability of long-term care insurance products including the  
35 products offered by the board.

36 (h) By December 1998, the health care authority, in consultation  
37 with the public employees' benefits board, shall submit a report to the

1 appropriate committees of the legislature, including an analysis of the  
2 marketing and distribution of the long-term care insurance provided  
3 under this section.

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