H-1883.1

HOUSE BILL 2199

State of Washington 60th Legislature 2007 Regular Session

By Representatives Hinkle, Bailey, Kretz, Ericksen, Chandler, Haler, Ahern, Roach, Warnick, Hailey, Newhouse, Skinner, Kristiansen, Dunn and Condotta

Read first time 02/13/2007. Referred to Committee on Health Care & Wellness.

AN ACT Relating to the Washington health opportunity act of 2007; amending RCW 48.21.045, 48.44.023, and 48.46.066; adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; adding a new section to chapter 82.04 RCW; creating new sections; and repealing 2006 c 100 s 7 (uncodified).

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05 RCW to read as follows:

(1) The authority shall issue a request for proposal for a Washington health insurance exchange by September 1, 2007. The exchange shall be designed to serve as a statewide, public-private partnership, offering maximum value for Washington state residents, through which nonlarge group health insurance may be bought and sold. Private entities may respond to the request for proposal. It is the goal of the exchange to:

(a) Ensure that employees of small businesses and other individuals can find affordable health insurance;

(b) Provide a mechanism for small businesses to contribute to their

employees' coverage without the administrative burden of directly shopping or contracting for insurance;

(c) Ensure that individuals can access coverage as they change and/or work in multiple jobs; and

(d) Coordinate with other state health insurance assistance programs, including the department of social and health services medical assistance programs and the authority's basic health program.

(2) In developing the request for proposal, the authority shall:

(a) Identify operational and governance issues to be addressed;

(b) Address key functions of the exchange, including but not limited to:

(i) Methods for small businesses and their employees to realize tax benefits from their financial contributions;

(ii) Options for offering choice among a broad array of affordable insurance products designed to meet individual needs, including waiving some current regulatory requirements. Options may include a health savings account/high deductible health plan, a comprehensive health benefit plan, and other plans;

(iii) Providing consumers a choice of health insurance products to allow them to choose the coverage that is right for them;

(iv) Aggregating premium contributions for an individual from multiple sources: Employers, individuals, philanthropies, and government;

(v) Mechanisms to collect and distribute workers' enrollment information and premium payments to the health plan of their choice;

(vi) Mechanisms for spreading health risk widely to support health insurance premiums that are more affordable;

(vii) Opportunities to reward carriers and consumers whose behavior is consistent with quality, efficiency, and evidence-based best practices;

(viii) Coordination of the transmission of premium assistance payments with the department of social and health services for individuals eligible for the department's employer-sponsored insurance program.

(3) The authority shall notify the apparent successful bidder no later than December 1, 2007.

(4) The authority may enter into contracts to issue, distribute,

and administer grants that are necessary or proper to carry out the requirements of this section.

NEW SECTION. **Sec. 2.** This act may be cited as the Washington health opportunity act of 2007.

NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW to read as follows:

No later than two years after the exchange established under section 1 of this act begins operation and every year thereafter, the exchange shall conduct a study of the exchange and the persons enrolled in the exchange and shall submit a written report to the governor and the legislature on the status and activities of the exchange based on data collected in the study. The report shall also be available to the general public. The study shall review:

(1) The operation and administration of the exchange, including surveys and reports of health benefit plans available to participating individuals and on the experience of the plans. The experience on the plans shall include data on enrollees in the exchange, the operation and administration of the exchange premium assistance program, expenses, claims statistics, complaints data, how the exchange met its goals, and other information deemed pertinent by the exchange; and

(2) Any significant observations regarding utilization and adoption of the exchange.

Sec. 4. RCW 48.21.045 and 2004 c 244 s 1 are each amended to read as follows:

(1)((~~(a)~~)) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer offering a health benefit plan under this subsection shall clearly~~

~~disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

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

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.21.130 through 48.21.240, 48.21.244 through 48.21.280, 48.21.300 through 48.21.320, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

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

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

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

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

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

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

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

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool, ((~~such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

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

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

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

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

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

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

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

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

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

Sec. 5. RCW 48.44.023 and 2004 c 244 s 7 are each amended to read as follows:

(1)((~~(a)~~)) A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A contractor offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.~~

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

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.44.210, 48.44.212, 48.44.225, 48.44.240 through 48.44.245, 48.44.290 through 48.44.340, 48.44.344, 48.44.360 through 48.44.380, 48.44.400, 48.44.420, 48.44.440 through 48.44.460, 48.44.500, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

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

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

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

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

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

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

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

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

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

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

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

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

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

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

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

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

Sec. 6. RCW 48.46.066 and 2004 c 244 s 9 are each amended to read as follows:

(1)((~~(a)~~)) A health maintenance organization offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer ((~~a~~)) no more than one health benefit plan featuring a limited schedule of covered health care services. ((~~Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A health maintenance organization offering a health benefit plan under this subsection shall clearly disclose all the covered benefits to the small employer in a brochure filed with the commissioner.~~

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

~~physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.~~

~~(2)~~)) (a) The plan offered under this subsection may be offered with a choice of cost-sharing arrangements, and may, but is not required to, comply with: RCW 48.46.250, 48.46.272 through 48.46.290, 48.46.320, 48.46.350, 48.46.375, 48.46.440 through 48.46.460, 48.46.480, 48.46.490, 48.46.510, 48.46.520, 48.46.530, 48.46.565, 48.46.570, 48.46.575, 48.43.045(1) except as required in (b) of this subsection, 48.43.093, 48.43.115 through 48.43.185, 48.43.515(5), or 48.42.100.

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

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

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

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

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

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

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

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

(i) Except for small group health benefit plans that qualify as insurance coverage combined with a health savings account as defined by the United States internal revenue service, adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus ((~~four~~)) eight percentage points from the overall adjustment of a carrier's entire small group pool((~~, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the carrier's small group pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal~~)) if certified by a member of the American academy of actuaries, that: (i) The variation is a result of deductible leverage, benefit design, claims cost trend for the plan, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all small group benefit plans will have a revenue neutral effect on the health maintenance organization's small group pool. Variations of greater than eight percentage points are subject to review by the commissioner and must be approved or denied within thirty days of submittal. A variation that is not denied within ((~~sixty~~)) thirty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial ((~~within thirty days~~)) at the time of the denial.

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 7.** A new section is added to chapter 82.04 RCW to read as follows:

(1) In computing tax there may be deducted from the measure of tax the amount paid by small employers to provide health care services for its employees. Payments made by employees are not eligible for deduction under this subsection.

(2) For the purposes of this section, the following definitions apply:

(a) "Small employer" has the meaning provided in RCW 48.43.005;

(b) "Health care services" means a health benefit plan as defined in RCW 48.43.005, contributions to health savings accounts as defined by the United States internal revenue service, or other health care services purchased by the small employer for its employees.

NEW SECTION. **Sec. 8.** (1) The office of the insurance commissioner shall contract for an independent study of specific health benefit mandates, rating requirements, and other statutes and rules, as identified by in-state and out-of-state insurance carriers as contributing most to the cost of individual and small group health insurance, to determine the impact on premiums and individuals' health if those statutes or rules were amended or repealed.

(2) The office of the insurance commissioner shall submit an interim report to the governor and appropriate committees of the legislature by December 1, 2007, and a final report by December 1, 2008.

NEW SECTION. **Sec. 9.** 2006 c 100 s 7 (uncodified) is repealed.

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