CERTIFICATION OF ENROLLMENT

# ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1569

Chapter 260, Laws of 2007

(partial veto)

60th Legislature
2007 Regular Session

HEALTH INSURANCE--IMPROVING COVERAGE

EFFECTIVE DATE: 07/22/07

Passed by the House April 16, 2007
Yeas 61 Nays 34

FRANK CHOPP

**Speaker of the House of Representatives**

Passed by the Senate April 12, 2007
Yeas 28 Nays 20

BRAD OWEN

**President of the Senate**

Approved May 2, 2007, 10:38 a.m., with the exception of sections 3 and 17 which are vetoed.

CHRISTINE GREGOIRE

**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 SECOND SUBSTITUTE HOUSE BILL 1569** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

**Chief Clerk**

FILED

May 3, 2007

**Secretary of State**
**State of Washington**

# ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1569

AS AMENDED BY THE SENATE

Passed Legislature - 2007 Regular Session

**State of Washington 60th Legislature 2007 Regular Session**

**By** House Committee on Appropriations (originally sponsored by Representatives Cody, Campbell, Morrell, Linville, Moeller, Green, Seaquist, Conway, Dickerson, Appleton, McIntire, McCoy, Kagi, Pedersen, Kenney, Lantz, Santos, Wood and Ormsby)

READ FIRST TIME 03/05/07.

AN ACT Relating to improving health insurance coverage by establishing a health insurance partnership for the purchase of small employer health insurance coverage, evaluating the inclusion of additional health insurance markets in the health insurance partnership, and studying the impact of health insurance mandates; amending RCW 70.47A.010, 70.47A.020, 70.47A.030, 70.47A.040, 48.21.045, 48.44.023, 48.46.066, 70.47A.050, 70.47A.060, and 70.47A.080; adding new sections to chapter 70.47A RCW; creating new sections; repealing 2006 c 255 s 10 (uncodified); providing an effective date; and declaring an emergency.

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

**Sec. 1.** RCW 70.47A.010 and 2006 c 255 s 1 are each amended to read as follows:

(1) The legislature finds that many small employers struggle with the cost of providing employer-sponsored health insurance coverage to their employees, while others are unable to offer employer-sponsored health insurance due to its high cost. Low-wage workers also struggle with the burden of paying their share of the costs of

employer-sponsored health insurance, while others turn down their employer's offer of coverage due to its costs.

(2) The legislature intends, through establishment of a ((~~small employer~~)) health insurance partnership program, to remove economic barriers to health insurance coverage for low-wage employees of small employers by building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

**Sec. 2.** RCW 70.47A.020 and 2006 c 255 s 2 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administrator" means the administrator of the Washington state health care authority, established under chapter 41.05 RCW.

(2) "Board" means the health insurance partnership board established in section 4 of this act.

(3) "Eligible ((~~employee~~)) partnership participant" means an individual who:

(a) Is a resident of the state of Washington;

(b) Has family income ((~~less than~~)) that does not exceed two hundred percent of the federal poverty level, as determined annually by the federal department of health and human services; and

(c) Is employed by a participating small employer or is a former employee of a participating small employer who chooses to continue receiving coverage through the partnership following separation from employment.

((~~(3)~~)) (4) "Health benefit plan" has the same meaning as defined in RCW 48.43.005 ((~~or any plan provided by a self-funded multiple employer welfare arrangement as defined in RCW 48.125.010 or by another benefit arrangement defined in the federal employee retirement income security act of 1974, as amended~~)).

((~~(4) "Program"~~)) (5) "Participating small employer" means a small employer that employs at least one eligible partnership participant and has entered into an agreement with the partnership for the partnership to offer and administer the small employer's group health benefit plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1167), for enrollees in the plan.

(6) "Partnership" means the ((~~small employer~~)) health insurance partnership ((~~program~~)) established in RCW 70.47A.030.

((~~(5)~~)) (7) "Partnership participant" means an employee of a participating small employer, or a former employee of a participating small employer who chooses to continue receiving coverage through the partnership following separation from employment.

(8) "Small employer" has the same meaning as defined in RCW 48.43.005.

((~~(6)~~)) (9) "Subsidy" or "premium subsidy" means payment or reimbursement to an eligible ((~~employee~~)) partnership participant toward the purchase of a health benefit plan, and may include a net billing arrangement with insurance carriers or a prospective or retrospective payment for health benefit plan premiums.

***Sec. 3. RCW 70.47A.030 and 2006 c 255 s 3 are each amended to read as follows:***

***(1) To the extent funding is appropriated in the operating budget for this purpose, the ((~~small employer~~)) health insurance partnership ((~~program~~)) is established. The administrator shall be responsible for the implementation and operation of the ((~~small employer~~)) health insurance partnership ((~~program~~)), directly or by contract. The administrator shall offer premium subsidies to eligible ((~~employees~~)) partnership participants under RCW 70.47A.040.***

***(2) Consistent with policies adopted by the board under section 4 of this act, the administrator shall, directly or by contract:***

***(a) Establish and administer procedures for enrolling small employers in the partnership, including publicizing the existence of the partnership and disseminating information on enrollment, and establishing rules related to minimum participation of employees in small groups purchasing health insurance through the partnership. Opportunities to publicize the program for outreach and education of small employers on the value of insurance shall explore the use of online employer guides. As a condition of participating in the partnership, a small employer must agree to establish a cafeteria plan under section 125 of the federal internal revenue code that will enable employees to use pretax dollars to pay their share of their health benefit plan premium. The partnership shall provide technical assistance to small employers for this purpose;***

***(b) Establish and administer procedures for health benefit plan enrollment by employees of small employers during open enrollment periods and outside of open enrollment periods upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law. Neither the employer nor the partnership shall limit an employee's choice of coverage from among all the health benefit plans offered;***

***(c) Establish and manage a system for the partnership to be designated as the sponsor or administrator of a participating small employer health benefit plan and to undertake the obligations required of a plan administrator under federal law;***

***(d) Establish and manage a system of collecting and transmitting to the applicable carriers all premium payments or contributions made by or on behalf of partnership participants, including employer contributions, automatic payroll deductions for partnership participants, premium subsidy payments, and contributions from philanthropies;***

***(e) Establish and manage a system for determining eligibility for and making premium subsidy payments under this act;***

***(f) Establish a mechanism to apply a surcharge to all health benefit plans, which shall be used only to pay for administrative and operational expenses of the partnership. The surcharge must be applied uniformly to all health benefit plans offered through the partnership and must be included in the premium for each health benefit plan. Surcharges may not be used to pay any premium assistance payments under this chapter;***

***(g) Design a schedule of premium subsidies that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members based on a benchmark health benefit plan designated by the board. The amount of an eligible partnership participant's premium subsidy shall be determined by applying a sliding scale subsidy schedule with the percentage of premium similar to that developed for subsidized basic health plan enrollees under RCW 70.47.060. The subsidy shall be applied to the employee's premium obligation for his or her health benefit plan, so that employees benefit financially from any employer contribution to the cost of their coverage through the partnership. Employees shall not be eligible for premium assistance if they have immediately transitioned from employer-***

***sponsored insurance, until they have fulfilled a six-month waiting period. During that time, the employee may participate in the program but not receive state-sponsored premium assistance.***

***(3) The administrator may enter into interdepartmental agreements with the office of the insurance commissioner, the department of social and health services, and any other state agencies necessary to implement this chapter.***

***Sec. 3 was vetoed. See message at end of chapter.***

NEW SECTION. **Sec. 4.** A new section is added to chapter 70.47A RCW to read as follows:

(1) The health insurance partnership board is hereby established. The governor shall appoint a seven-member health insurance partnership board by June 30, 2007. The board shall be composed of persons with expertise in the health insurance market and benefit design, and be chaired by the administrator.

(2) The governor shall appoint the initial members of the board to staggered terms not to exceed four years. Initial appointments shall be made on or before June 1, 2007. Members appointed thereafter shall serve two-year terms. Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. Meetings of the board shall be at the call of the chair.

(3) The board may establish technical advisory committees or seek the advice of technical experts when necessary to execute the powers and duties included in this section.

(4) The board and employees of the board shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. Nothing in this section prohibits legal actions against the board to enforce the board's statutory or contractual duties or obligations.

NEW SECTION. **Sec. 5.** A new section is added to chapter 70.47A RCW to read as follows:

(1) The health insurance partnership board shall:

(a) Develop policies for enrollment of small employers in the partnership, including minimum participation rules for small employer groups. The small employer shall determine the criteria for eligibility and enrollment in his or her plan and the terms and amounts of the employer's contributions to that plan, consistent with any minimum employer premium contribution level established by the board under (d) of this subsection;

(b) Designate health benefit plans that are currently offered in the small group market that will qualify for premium subsidy payments. At least four health benefit plans shall be chosen, with multiple deductible and point-of-service cost-sharing options. The health benefit plans shall range from catastrophic to comprehensive coverage, and one health benefit plan shall be a high deductible health plan. Every effort shall be made to include health benefit plans that include components to maximize the quality of care provided and result in improved health outcomes, such as preventive care, wellness incentives, chronic care management services, and provider network development and payment policies related to quality of care;

(c) Approve a mid-range benefit plan from those selected to be used as a benchmark plan for calculating premium subsidies;

(d) Determine whether there should be a minimum employer premium contribution on behalf of employees, and if so, how much;

(e) Determine appropriate health benefit plan rating methodologies. The methodologies shall be based on the small group adjusted community rate as defined in Title 48 RCW. The board shall evaluate the impact of applying the small group community rating with the partnership principle of allowing each employee to choose their health benefit plan, and consider options to reduce uncertainty for carriers and provide for efficient risk management of high-cost enrollees through risk adjustment, reinsurance, or other mechanisms;

(f) Conduct analyses and provide recommendations as requested by the legislature and the governor, with the assistance of staff from the health care authority and the office of the insurance commissioner.

(2) The board may authorize one or more limited health care service plans for dental care services to be offered by limited health care service contractors under RCW 48.44.035. However, such plan shall not qualify for subsidy payments.

(3) In fulfilling the requirements of this section, the board shall consult with small employers, the office of the insurance commissioner, members in good standing of the American academy of actuaries, health carriers, agents and brokers, and employees of small business.

**Sec. 6.** RCW 70.47A.040 and 2006 c 255 s 4 are each amended to read as follows:

((~~(1)~~)) Beginning ((~~July 1, 2007~~)) September 1, 2008, the administrator shall accept applications from eligible ((~~employees~~)) partnership participants, on behalf of themselves, their spouses, and their dependent children, to receive premium subsidies through the ((~~small employer~~)) health insurance partnership ((~~program~~)).

((~~(2) Premium subsidy payments may be provided to eligible employees if:~~

~~(a) The eligible employee is employed by a small employer;~~

~~(b) The actuarial value of the health benefit plan offered by the small employer is at least equivalent to that of the basic health plan benefit offered under chapter 70.47 RCW. The office of the insurance commissioner under Title 48 RCW shall certify those small employer health benefit plans that are at least actuarially equivalent to the basic health plan benefit; and~~

~~(c) The small employer will pay at least forty percent of the monthly premium cost for health benefit plan coverage of the eligible employee.~~

~~(3) The amount of an eligible employee's premium subsidy shall be determined by applying the sliding scale subsidy schedule developed for subsidized basic health plan enrollees under RCW 70.47.060 to the employee's premium obligation for his or her employer's health benefit plan.~~

~~(4) After an eligible individual has enrolled in the program, the program shall issue subsidies in an amount determined pursuant to subsection (3) of this section to either the eligible employee or to the carrier designated by the eligible employee.~~

~~(5) An eligible employee must agree to provide verification of continued enrollment in his or her small employer's health benefit plan on a semiannual basis or to notify the administrator whenever his or her enrollment status changes, whichever is earlier. Verification or notification may be made directly by the employee, or through his or~~

~~her employer or the carrier providing the small employer health benefit plan. When necessary, the administrator has the authority to perform retrospective audits on premium subsidy accounts. The administrator may suspend or terminate an employee's participation in the program and seek repayment of any subsidy amounts paid due to the omission or misrepresentation of an applicant or enrolled employee. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources.~~))

**Sec. 7.** 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 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) 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) 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).

(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. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four 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. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

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

(5)(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) 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) 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. 8.** 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 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) 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) 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).

(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. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four 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. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a

detailed actuarial justification for any denial within thirty days of the denial.

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

(5)(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) 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. 9.** 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 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) 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) 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).

(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. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four 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. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

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

(5)(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) 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. 10.** On or before December 1, 2008, the health insurance partnership board shall submit a preliminary report to the governor and the legislature that includes an implementation plan to incorporate the individual and small group health insurance markets into the partnership program. In preparing the report, the board shall examine at least the following issues:

(1) The impact of these markets being incorporated into the partnership, with respect to the utilization of services and cost of health plans offered through the partnership;

(2) The impact of applying small group health benefit plan regulations on access to health services and the cost of coverage for these markets; and

(3) How the composition of the board should be modified to reflect the incorporation of the individual and small group markets in the partnership.

NEW SECTION. **Sec. 11.** On or before September 1, 2009, the health insurance partnership board shall submit a report and recommendations to the governor and the legislature regarding:

(1) The risks and benefits of additional markets participating in the partnership:

(a) The report shall examine the following markets:

(i) Washington state health insurance pool under chapter 48.41 RCW;

(ii) Basic health plan under chapter 70.47 RCW;

(iii) Public employees' benefits board enrollees under chapter 41.05 RCW;

(iv) Public school employees; and

(v) Any final recommendations for the individual and small group markets, relevant to the study outlined in section 10 of this act; and

(b) The report shall examine at least the following issues:

(i) The impact of these markets participating in the partnership,

with respect to the utilization of services and cost of health plans offered through the partnership;

(ii) Whether any distinction should be made in participation between active and retired employees enrolled in public employees' benefits board plans, giving consideration to the implicit subsidy that nonmedicare-eligible retirees currently benefit from by being pooled with active employees, and how medicare-eligible retirees would be affected;

(iii) The impact of applying small group health benefit plan regulations on access to health services and the cost of coverage for these markets; and

(iv) If the board recommends the inclusion of additional markets, how the composition of the board should be modified to reflect the participation of these markets; and

(2) The risks and benefits of establishing a requirement that residents of the state of Washington age eighteen and over obtain and maintain affordable creditable coverage, as defined in the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg(c)). The report shall address the question of how a requirement that residents maintain coverage could be enforced in the state of Washington.

**Sec. 12.** RCW 70.47A.050 and 2006 c 255 s 5 are each amended to read as follows:

Enrollment in the ((~~small employer~~)) health insurance partnership ((~~program~~)) is not an entitlement and shall not result in expenditures that exceed the amount that has been appropriated for the program in the operating budget. If it appears that continued enrollment will result in expenditures exceeding the appropriated level for a particular fiscal year, the administrator may freeze new enrollment in the program and establish a waiting list of eligible employees who shall receive subsidies only when sufficient funds are available.

**Sec. 13.** RCW 70.47A.060 and 2006 c 255 s 6 are each amended to read as follows:

The administrator shall adopt all rules necessary for the implementation and operation of the ((~~small employer~~)) health insurance partnership ((~~program~~)). As part of the rule development process, the

administrator shall consult with small employers, carriers, employee organizations, and the office of the insurance commissioner under Title 48 RCW to determine an effective and efficient method for the payment of subsidies under this chapter. All rules shall be adopted in accordance with chapter 34.05 RCW.

**Sec. 14.** RCW 70.47A.080 and 2006 c 255 s 8 are each amended to read as follows:

The ((~~small employer~~)) health insurance partnership ((~~program~~)) account is hereby established in the custody of the state treasurer. Any nongeneral fund--state funds collected for the ((~~small employer~~)) health insurance partnership ((~~program~~)) shall be deposited in the ((~~small employer~~)) health insurance partnership ((~~program~~)) account. Moneys in the account shall be used exclusively for the purposes of administering the ((~~small employer~~)) health insurance partnership ((~~program~~)), including payments to ((~~participating managed health care systems~~)) insurance carriers on behalf of ((~~small employer~~)) health insurance partnership enrollees. Only the administrator of the health care authority or his or her designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 15.** (1) The office of the insurance commissioner shall contract for an independent study of health benefit mandates, rating requirements, and insurance statutes and rules 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. 16.** 2006 c 255 s 10 (uncodified) is repealed.

***NEW SECTION. Sec. 17. Sections 1 through 6 of this act are necessary for the immediate preservation of the public peace, health,**

***or safety, or support of the state government and its existing public institutions, and take effect July 1, 2007.***

***Sec. 17 was vetoed. See message at end of chapter.***

NEW SECTION. **Sec. 18.** If specific funding for the purposes of the following sections of this act, referencing the section of this act by bill or chapter number and section number, is not provided by June 30, 2007, in the omnibus appropriations act, the section is null and void:

(1) Section 5 (health insurance partnership board);

(2) Section 15 (office of insurance commissioner independent study).

Passed by the House April 16, 2007.
Passed by the Senate April 12, 2007.
Approved by the Governor May 2, 2007, with the exception of certain items that were vetoed.
Filed in Office of Secretary of State May 3, 2007.

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

"I am returning, without my approval as to Sections 3 and 17, Engrossed Second Substitute House Bill 1569 entitled:

"AN ACT Relating to improving health insurance coverage by establishing a health insurance partnership for the purchase of small employer health insurance coverage, evaluating the inclusion of additional health insurance markets in the health insurance partnership, and studying the impact of health insurance mandates."

This bill creates the Washington Health Insurance Partnership (WHP), an innovative approach to providing affordable health care in this state. By combining public and private resources, and creating a mechanism to organize and improve access to the insurance market, WHP will offer choice and assistance to small business employees seeking coverage for themselves and their families, and I welcome it.

Section 3 of the bill, which sets forth many of the operational details of the WHP program, is virtually identical to Section 58 of Engrossed Second Substitute Senate Bill 5930. However, it adds the requirement that eligible employees who transition from employer-sponsored insurance to the WHP program wait six months before receiving a subsidy. This requirement could unintentionally delay assistance to someone at the very point they most need it -- when they have lost their job and are attempting to retain health benefits provided through the WHP.

Section 17 of the bill is an emergency clause, and would allow certain sections of the bill to become effective on July 1. The emergency clause is not essential to the proper and timely implementation of the bill.

For these reasons, I have vetoed Sections 3 and 17 of Engrossed Second Substitute House Bill 1569.

With the exception of Sections 3 and 17, Engrossed Second Substitute House Bill 1569 is approved."