CERTIFICATION OF ENROLLMENT

SECOND SUBSTITUTE HOUSE BILL 2537

Chapter 143, Laws of 2008

60th Legislature
2008 Regular Session

HEALTH INSURANCE PARTNERSHIP

EFFECTIVE DATE: 06/12/08

Passed by the House March 10, 2008
Yeas 63 Nays 32

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 7, 2008
Yeas 27 Nays 22

BRAD OWEN

President of the Senate

Approved March 25, 2008, 1:32 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Barbara Baker, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE HOUSE BILL 2537** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BARBARA BAKER

Chief Clerk

FILED

March 25, 2008

Secretary of State
State of Washington

SECOND SUBSTITUTE HOUSE BILL 2537

AS AMENDED BY THE SENATE

Passed Legislature - 2008 Regular Session

State of Washington 60th Legislature 2008 Regular Session

By House Appropriations (originally sponsored by Representatives Cody, Hasegawa, Kenney, Morrell, Green, and Loomis)

READ FIRST TIME 02/12/08.

AN ACT Relating to modifications to the health insurance partnership statute necessary for timely implementation of the health insurance partnership; amending RCW 70.47A.020, 70.47A.030, 70.47A.040, 70.47A.070, 70.47A.110, 48.21.045, 48.44.023, and 48.46.066; and creating a new section.

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

Sec. 1. RCW 70.47A.020 and 2007 c 260 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 RCW 70.47A.100.

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

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

(b) Has family income 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~~)).

(4) "Health benefit plan" has the same meaning as defined in RCW 48.43.005.

(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~~)) to purchase health benefits through the partnership. To participate in the partnership, an employer must attest to the fact that (a) the employer does not currently offer health insurance to its employees, and (b) at least fifty percent of the employer's employees are low-wage workers.

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

(7) "Partnership participant" means ((~~an employee~~)) a participating small employer and employees of a participating small employer, ((~~or~~)) and, except to the extent provided otherwise in RCW 70.47A.110(1)(e), 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.

(9) "Subsidy" or "premium subsidy" means payment or reimbursement to an eligible 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. 2. RCW 70.47A.030 and 2007 c 259 s 58 are each amended to read as follows:

(1) To the extent funding is appropriated in the operating budget for this purpose, the health insurance partnership is established. The

administrator shall be responsible for the implementation and operation of the health insurance partnership, directly or by contract. The administrator shall offer premium subsidies to eligible partnership participants under RCW 70.47A.040. The partnership shall begin to offer coverage no later than March 1, 2009.

(2) Consistent with policies adopted by the board under ((~~section 59 of this act~~)) RCW 70.47A.110, 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~~)) Except to the extent authorized in RCW 70.47A.110(1)(e), neither the employer nor the partnership shall limit an employee's choice of coverage from among ((~~all~~)) the health benefit plans offered through the partnership;

(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)~~)) (d) Establish and manage a system for determining eligibility for and making premium subsidy payments under chapter 259, Laws of 2007;

((~~(f)~~)) (e) Establish a mechanism to apply a surcharge to ((~~all~~)) each health benefit plan((~~s~~)) purchased through the partnership, 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~~)) purchased through the partnership ((~~and must be included in the premium for each health benefit plan~~)). Any surcharge amount may be added to the premium, but shall not be considered part of the small group community rate, and shall be applied only to the coverage purchased through the partnership. Surcharges may not be used to pay any premium assistance payments under this chapter. The surcharge shall reflect administrative and operational expenses remaining after any appropriation provided by the legislature to support administrative or operational expenses of the partnership during the year the surcharge is assessed;

((~~(g)~~)) (f) 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.

(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. RCW 70.47A.040 and 2007 c 260 s 6 are each amended to read as follows:

Beginning ((~~September 1, 2008~~)) January 1, 2009, the administrator shall accept applications from eligible partnership participants, on behalf of themselves, their spouses, and their dependent children, to receive premium subsidies through the health insurance partnership. Every effort shall be made to coordinate premium subsidies for dependent children with federal funding available under Title XIX and Title XXI of the federal social security act, consistent with the requirements established in RCW 74.09.470(4) for the employer-sponsored insurance program at the department of social and health services.

Sec. 4. RCW 70.47A.070 and 2006 c 255 s 7 are each amended to read as follows:

The administrator shall report biennially, beginning November 1, 2010, to the relevant policy and fiscal committees of the legislature on the effectiveness and efficiency of the ((~~small employer~~)) health insurance partnership program, including enrollment trends, the services and benefits covered under the purchased health benefit plans, consumer satisfaction, and other program operational issues.

Sec. 5. RCW 70.47A.110 and 2007 c 260 s 5 are each amended 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 be offered to participating small employers through the health insurance partnership and those plans that will qualify for premium subsidy payments. ((~~At least four~~)) Up to five 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 accompanied by a health savings account. 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) Develop policies related to partnership participant enrollment in health benefit plans. The board may focus its initial efforts on access to coverage and affordability of coverage for participating small employers and their employees. To the extent necessary for successful implementation of the partnership, during a start-up phase of partnership operation, the board may:

(i) Limit partnership participant health benefit plan choice; and

(ii) Offer former employees of participating small employers the opportunity to continue coverage after separation from employment to the extent that a former employee is eligible for continuation coverage under 29 U.S.C. Sec. 1161 et seq.

The start-up phase may not exceed two years from the date the partnership begins to offer coverage;

(f) 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 adjusted community rating ((~~with~~)) methodology to health benefit plans purchased through the partnership on the ((~~partnership~~)) principle of allowing each ((~~employee~~)) partnership participant to choose ((~~their~~)) his or her health benefit plan, and ((~~consider options~~)) may implement one or more risk adjustment or reinsurance mechanisms to reduce uncertainty for carriers and provide for efficient risk management of high-cost enrollees ((~~through risk adjustment, reinsurance, or other mechanisms~~));

((~~(f)~~)) (g) Determine whether the partnership should be designated as the administrator of a participating small employer health benefit plan and undertake the obligations required of a plan administrator under federal law in order to minimize administrative burdens on participating small employers;

(h) 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 48.21.045 and 2007 c 260 s 7 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.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other

factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(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.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(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. 7. RCW 48.44.023 and 2007 c 260 s 8 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.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(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.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(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. 8. RCW 48.46.066 and 2007 c 260 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.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(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.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(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. 9.** If specific funding for the purposes of this act, referencing this act by bill or chapter number, is not provided by June 30, 2008, in the omnibus appropriations act, this act is null and void.

Passed by the House March 10, 2008.
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Approved by the Governor March 25, 2008.
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