

CERTIFICATION OF ENROLLMENT

**ENGROSSED SUBSTITUTE SENATE BILL 6538**

Chapter 292, Laws of 2010

61st Legislature  
2010 Regular Session

INSURANCE--SMALL EMPLOYER OR GROUP COVERAGE

EFFECTIVE DATE: 06/10/10

Passed by the Senate March 10, 2010  
YEAS 47 NAYS 0

BRAD OWEN

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**President of the Senate**

Passed by the House March 9, 2010  
YEAS 61 NAYS 36

FRANK CHOPP

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**Speaker of the House of Representatives**

Approved April 1, 2010, 3:31 p.m.

CHRISTINE GREGOIRE

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**Governor of the State of Washington**

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 6538** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

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**Secretary**

FILED

April 2, 2010

**Secretary of State  
State of Washington**

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**ENGROSSED SUBSTITUTE SENATE BILL 6538**

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AS AMENDED BY THE HOUSE

Passed Legislature - 2010 Regular Session

**State of Washington                      61st Legislature                      2010 Regular Session**

**By** Senate Health & Long-Term Care (originally sponsored by Senators Keiser and Pflug)

READ FIRST TIME 02/05/10.

1            AN ACT Relating to the definition of small groups for insurance  
2 purposes; amending RCW 48.43.035, 48.44.010, 48.44.023, 48.46.020,  
3 48.46.066, 48.21.045, and 48.21.047; reenacting and amending RCW  
4 48.43.005; creating a new section; providing a contingent effective  
5 date; and providing a contingent expiration date.

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

7            **Sec. 1.** RCW 48.43.005 and 2008 c 145 s 20 and 2008 c 144 s 1 are  
8 each reenacted and amended to read as follows:

9            Unless otherwise specifically provided, the definitions in this  
10 section apply throughout this chapter.

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

15            (2) "Basic health plan" means the plan described under chapter  
16 70.47 RCW, as revised from time to time.

17            (3) "Basic health plan model plan" means a health plan as required  
18 in RCW 70.47.060(2)(e).

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

5 (5) "Catastrophic health plan" means:

6 (a) In the case of a contract, agreement, or policy covering a  
7 single enrollee, a health benefit plan requiring a calendar year  
8 deductible of, at a minimum, one thousand seven hundred fifty dollars  
9 and an annual out-of-pocket expense required to be paid under the plan  
10 (other than for premiums) for covered benefits of at least three  
11 thousand five hundred dollars, both amounts to be adjusted annually by  
12 the insurance commissioner; and

13 (b) In the case of a contract, agreement, or policy covering more  
14 than one enrollee, a health benefit plan requiring a calendar year  
15 deductible of, at a minimum, three thousand five hundred dollars and an  
16 annual out-of-pocket expense required to be paid under the plan (other  
17 than for premiums) for covered benefits of at least six thousand  
18 dollars, both amounts to be adjusted annually by the insurance  
19 commissioner; or

20 (c) Any health benefit plan that provides benefits for hospital  
21 inpatient and outpatient services, professional and prescription drugs  
22 provided in conjunction with such hospital inpatient and outpatient  
23 services, and excludes or substantially limits outpatient physician  
24 services and those services usually provided in an office setting.

25 In July 2008, and in each July thereafter, the insurance  
26 commissioner shall adjust the minimum deductible and out-of-pocket  
27 expense required for a plan to qualify as a catastrophic plan to  
28 reflect the percentage change in the consumer price index for medical  
29 care for a preceding twelve months, as determined by the United States  
30 department of labor. The adjusted amount shall apply on the following  
31 January 1st.

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

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

3 (8) "Covered person" or "enrollee" means a person covered by a  
4 health plan including an enrollee, subscriber, policyholder,  
5 beneficiary of a group plan, or individual covered by any other health  
6 plan.

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

10 (10) "Employee" has the same meaning given to the term, as of  
11 January 1, 2008, under section 3(6) of the federal employee retirement  
12 income security act of 1974.

13 (11) "Emergency medical condition" means the emergent and acute  
14 onset of a symptom or symptoms, including severe pain, that would lead  
15 a prudent layperson acting reasonably to believe that a health  
16 condition exists that requires immediate medical attention, if failure  
17 to provide medical attention would result in serious impairment to  
18 bodily functions or serious dysfunction of a bodily organ or part, or  
19 would place the person's health in serious jeopardy.

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

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

27 (14) "Grievance" means a written complaint submitted by or on  
28 behalf of a covered person regarding: (a) Denial of payment for  
29 medical services or nonprovision of medical services included in the  
30 covered person's health benefit plan, or (b) service delivery issues  
31 other than denial of payment for medical services or nonprovision of  
32 medical services, including dissatisfaction with medical care, waiting  
33 time for medical services, provider or staff attitude or demeanor, or  
34 dissatisfaction with service provided by the health carrier.

35 (15) "Health care facility" or "facility" means hospices licensed  
36 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,  
37 rural health care facilities as defined in RCW 70.175.020, psychiatric  
38 hospitals licensed under chapter 71.12 RCW, nursing homes licensed

1 under chapter 18.51 RCW, community mental health centers licensed under  
2 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed  
3 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical  
4 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment  
5 facilities licensed under chapter 70.96A RCW, and home health agencies  
6 licensed under chapter 70.127 RCW, and includes such facilities if  
7 owned and operated by a political subdivision or instrumentality of the  
8 state and such other facilities as required by federal law and  
9 implementing regulations.

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

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

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

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

19 (18) "Health carrier" or "carrier" means a disability insurer  
20 regulated under chapter 48.20 or 48.21 RCW, a health care service  
21 contractor as defined in RCW 48.44.010, or a health maintenance  
22 organization as defined in RCW 48.46.020.

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

26 (a) Long-term care insurance governed by chapter 48.84 or 48.83  
27 RCW;

28 (b) Medicare supplemental health insurance governed by chapter  
29 48.66 RCW;

30 (c) Coverage supplemental to the coverage provided under chapter  
31 55, Title 10, United States Code;

32 (d) Limited health care services offered by limited health care  
33 service contractors in accordance with RCW 48.44.035;

34 (e) Disability income;

35 (f) Coverage incidental to a property/casualty liability insurance  
36 policy such as automobile personal injury protection coverage and  
37 homeowner guest medical;

38 (g) Workers' compensation coverage;

1 (h) Accident only coverage;  
2 (i) Specified disease or illness-triggered fixed payment insurance,  
3 hospital confinement fixed payment insurance, or other fixed payment  
4 insurance offered as an independent, noncoordinated benefit;  
5 (j) Employer-sponsored self-funded health plans;  
6 (k) Dental only and vision only coverage; and  
7 (l) Plans deemed by the insurance commissioner to have a short-term  
8 limited purpose or duration, or to be a student-only plan that is  
9 guaranteed renewable while the covered person is enrolled as a regular  
10 full-time undergraduate or graduate student at an accredited higher  
11 education institution, after a written request for such classification  
12 by the carrier and subsequent written approval by the insurance  
13 commissioner.

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

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

20 (22) "Premium" means all sums charged, received, or deposited by a  
21 health carrier as consideration for a health plan or the continuance of  
22 a health plan. Any assessment or any "membership," "policy,"  
23 "contract," "service," or similar fee or charge made by a health  
24 carrier in consideration for a health plan is deemed part of the  
25 premium. "Premium" shall not include amounts paid as enrollee point-  
26 of-service cost-sharing.

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

32 (24) "Small employer" or "small group" means any person, firm,  
33 corporation, partnership, association, political subdivision, sole  
34 proprietor, or self-employed individual that is actively engaged in  
35 business that employed an average of at least (~~two~~) one but no more  
36 than fifty employees, during the previous calendar year and employed at  
37 least (~~two~~) one employee(~~s~~) on the first day of the plan year, is  
38 not formed primarily for purposes of buying health insurance, and in

1 which a bona fide employer-employee relationship exists. In  
2 determining the number of employees, companies that are affiliated  
3 companies, or that are eligible to file a combined tax return for  
4 purposes of taxation by this state, shall be considered an employer.  
5 Subsequent to the issuance of a health plan to a small employer and for  
6 the purpose of determining eligibility, the size of a small employer  
7 shall be determined annually. Except as otherwise specifically  
8 provided, a small employer shall continue to be considered a small  
9 employer until the plan anniversary following the date the small  
10 employer no longer meets the requirements of this definition. A self-  
11 employed individual or sole proprietor (~~who is covered as a group of~~  
12 ~~one on the day prior to June 10, 2004, shall also be considered a~~  
13 ~~"small employer" to the extent that individual or group of one is~~  
14 ~~entitled to have his or her coverage renewed as provided in RCW~~  
15 ~~48.43.035(6))~~ who is covered as a group of one must also: (a) Have  
16 been employed by the same small employer or small group for at least  
17 twelve months prior to application for small group coverage, and (b)  
18 verify that he or she derived at least seventy-five percent of his or  
19 her income from a trade or business through which the individual or  
20 sole proprietor has attempted to earn taxable income and for which he  
21 or she has filed the appropriate internal revenue service form 1040,  
22 schedule C or F, for the previous taxable year, except a self-employed  
23 individual or sole proprietor in an agricultural trade or business,  
24 must have derived at least fifty-one percent of his or her income from  
25 the trade or business through which the individual or sole proprietor  
26 has attempted to earn taxable income and for which he or she has filed  
27 the appropriate internal revenue service form 1040, for the previous  
28 taxable year.

29 (25) "Utilization review" means the prospective, concurrent, or  
30 retrospective assessment of the necessity and appropriateness of the  
31 allocation of health care resources and services of a provider or  
32 facility, given or proposed to be given to an enrollee or group of  
33 enrollees.

34 (26) "Wellness activity" means an explicit program of an activity  
35 consistent with department of health guidelines, such as, smoking  
36 cessation, injury and accident prevention, reduction of alcohol misuse,  
37 appropriate weight reduction, exercise, automobile and motorcycle

1 safety, blood cholesterol reduction, and nutrition education for the  
2 purpose of improving enrollee health status and reducing health service  
3 costs.

4 **Sec. 2.** RCW 48.43.035 and 2004 c 244 s 4 are each amended to read  
5 as follows:

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

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

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

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

- 30 (a) Nonpayment of premium;
- 31 (b) Violation of published policies of the carrier approved by the  
32 insurance commissioner;
- 33 (c) Covered persons entitled to become eligible for medicare  
34 benefits by reason of age who fail to apply for a medicare supplement  
35 plan or medicare cost, risk, or other plan offered by the carrier  
36 pursuant to federal laws and regulations;

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

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

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

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

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

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

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

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

31 (d) A carrier discontinues offering all health coverage in the  
32 small group market or for groups of up to two hundred, or both markets,  
33 in the state and discontinues coverage under all existing group health  
34 benefit plans in the applicable market involved if: (i) The carrier  
35 provides notice to the commissioner of its intent to discontinue  
36 offering all such coverage in the state and its intent to discontinue  
37 coverage under all such existing health benefit plans at least one  
38 hundred eighty days prior to the date of the discontinuation of

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

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

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

22 ~~((6) Notwithstanding any other provision of this section, the~~  
23 ~~guarantee of continuity of coverage applies to a group of one only if:~~  
24 ~~(a) The carrier continues to offer any other small employer group plan~~  
25 ~~in which the group of one was eligible to enroll on the day prior to~~  
26 ~~June 10, 2004; and (b) the person continues to qualify as a group of~~  
27 ~~one under the criteria in place on the day prior to June 10, 2004.))~~

28 **Sec. 3.** RCW 48.44.010 and 2007 c 267 s 2 are each amended to read  
29 as follows:

30 For the purposes of this chapter:

31 (1) "Health care services" means and includes medical, surgical,  
32 dental, chiropractic, hospital, optometric, podiatric, pharmaceutical,  
33 ambulance, custodial, mental health, and other therapeutic services.

34 (2) "Provider" means any health professional, hospital, or other  
35 institution, organization, or person that furnishes health care  
36 services and is licensed to furnish such services.

1 (3) "Health care service contractor" means any corporation,  
2 cooperative group, or association, which is sponsored by or otherwise  
3 intimately connected with a provider or group of providers, who or  
4 which not otherwise being engaged in the insurance business, accepts  
5 prepayment for health care services from or for the benefit of persons  
6 or groups of persons as consideration for providing such persons with  
7 any health care services. "Health care service contractor" does not  
8 include direct patient-provider primary care practices as defined in  
9 RCW 48.150.010.

10 (4) "Participating provider" means a provider, who or which has  
11 contracted in writing with a health care service contractor to accept  
12 payment from and to look solely to such contractor according to the  
13 terms of the subscriber contract for any health care services rendered  
14 to a person who has previously paid, or on whose behalf prepayment has  
15 been made, to such contractor for such services.

16 (5) "Enrolled participant" means a person or group of persons who  
17 have entered into a contractual arrangement or on whose behalf a  
18 contractual arrangement has been entered into with a health care  
19 service contractor to receive health care services.

20 (6) "Commissioner" means the insurance commissioner.

21 (7) "Uncovered expenditures" means the costs to the health care  
22 service contractor for health care services that are the obligation of  
23 the health care service contractor for which an enrolled participant  
24 would also be liable in the event of the health care service  
25 contractor's insolvency and for which no alternative arrangements have  
26 been made as provided herein. The term does not include expenditures  
27 for covered services when a provider has agreed not to bill the  
28 enrolled participant even though the provider is not paid by the health  
29 care service contractor, or for services that are guaranteed, insured  
30 or assumed by a person or organization other than the health care  
31 service contractor.

32 (8) "Copayment" means an amount specified in a group or individual  
33 contract which is an obligation of an enrolled participant for a  
34 specific service which is not fully prepaid.

35 (9) "Deductible" means the amount an enrolled participant is  
36 responsible to pay before the health care service contractor begins to  
37 pay the costs associated with treatment.

1 (10) "Group contract" means a contract for health care services  
2 which by its terms limits eligibility to members of a specific group.  
3 The group contract may include coverage for dependents.

4 (11) "Individual contract" means a contract for health care  
5 services issued to and covering an individual. An individual contract  
6 may include dependents.

7 (12) "Carrier" means a health maintenance organization, an insurer,  
8 a health care service contractor, or other entity responsible for the  
9 payment of benefits or provision of services under a group or  
10 individual contract.

11 (13) "Replacement coverage" means the benefits provided by a  
12 succeeding carrier.

13 (14) "Insolvent" or "insolvency" means that the organization has  
14 been declared insolvent and is placed under an order of liquidation by  
15 a court of competent jurisdiction.

16 (15) "Fully subordinated debt" means those debts that meet the  
17 requirements of RCW 48.44.037(3) and are recorded as equity.

18 (16) "Net worth" means the excess of total admitted assets as  
19 defined in RCW 48.12.010 over total liabilities but the liabilities  
20 shall not include fully subordinated debt.

21 (17) "Census date" means the date upon which a health care services  
22 contractor offering coverage to a small employer must base rate  
23 calculations. For a small employer applying for a health benefit plan  
24 through a contractor other than its current contractor, the census date  
25 is the date that final group composition is received by the contractor.  
26 For a small employer that is renewing its health benefit plan through  
27 its existing contractor, the census date is ninety days prior to the  
28 effective date of the renewal.

29 **Sec. 4.** RCW 48.44.023 and 2009 c 131 s 2 are each amended to read  
30 as follows:

31 (1)(a) A health care services contractor offering any health  
32 benefit plan to a small employer, either directly or through an  
33 association or member-governed group formed specifically for the  
34 purpose of purchasing health care, may offer and actively market to the  
35 small employer a health benefit plan featuring a limited schedule of  
36 covered health care services. Nothing in this subsection shall  
37 preclude a contractor from offering, or a small employer from

1 purchasing, other health benefit plans that may have more comprehensive  
2 benefits than those included in the product offered under this  
3 subsection. A contractor offering a health benefit plan under this  
4 subsection shall clearly disclose all covered benefits to the small  
5 employer in a brochure filed with the commissioner.

6 (b) A health benefit plan offered under this subsection shall  
7 provide coverage for hospital expenses and services rendered by a  
8 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
9 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,  
10 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,  
11 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

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

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

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

- 23 (i) Geographic area;
- 24 (ii) Family size;
- 25 (iii) Age; and
- 26 (iv) Wellness activities.

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

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

36 (d) The permitted rates for any age group shall be no more than  
37 four hundred twenty-five percent of the lowest rate for all age groups

1 on January 1, 1996, four hundred percent on January 1, 1997, and three  
2 hundred seventy-five percent on January 1, 2000, and thereafter.

3 (e) A discount for wellness activities shall be permitted to  
4 reflect actuarially justified differences in utilization or cost  
5 attributed to such programs. Up to a twenty percent variance may be  
6 allowed for small employers that develop and implement a wellness  
7 program or activities that directly improve employee wellness.  
8 Employers shall document program activities with the carrier and may,  
9 after three years of implementation, request a reduction in premiums  
10 based on improved employee health and wellness. While carriers may  
11 review the employer's claim history when making a determination  
12 regarding whether the employer's wellness program has improved employee  
13 health, the carrier may not use maternity or prevention services claims  
14 to deny the employer's request. Carriers may consider issues such as  
15 improved productivity or a reduction in absenteeism due to illness if  
16 submitted by the employer for consideration. Interested employers may  
17 also work with the carrier to develop a wellness program and a means to  
18 track improved employee health.

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

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

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

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

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

28 (g) On the census date, as defined in RCW 48.44.010, rating factors  
29 shall produce premiums for identical groups that differ only by the  
30 amounts attributable to plan design, and differences in census date  
31 between new and renewal groups, with the exception of discounts for  
32 health improvement programs.

33 (h) For the purposes of this section, a health benefit plan that  
34 contains a restricted network provision shall not be considered similar  
35 coverage to a health benefit plan that does not contain such a  
36 provision, provided that the restrictions of benefits to network  
37 providers result in substantial differences in claims costs. A carrier  
38 may develop its rates based on claims costs due to network provider

1 reimbursement schedules or type of network. This subsection does not  
2 restrict or enhance the portability of benefits as provided in RCW  
3 48.43.015.

4 (i) Adjusted community rates established under this section shall  
5 pool the medical experience of all groups purchasing coverage,  
6 including the small group participants in the health insurance  
7 partnership established in RCW 70.47A.030. However, annual rate  
8 adjustments for each small group health benefit plan may vary by up to  
9 plus or minus four percentage points from the overall adjustment of a  
10 carrier's entire small group pool, such overall adjustment to be  
11 approved by the commissioner, upon a showing by the carrier, certified  
12 by a member of the American academy of actuaries that: (i) The  
13 variation is a result of deductible leverage, benefit design, or  
14 provider network characteristics; and (ii) for a rate renewal period,  
15 the projected weighted average of all small group benefit plans will  
16 have a revenue neutral effect on the carrier's small group pool.  
17 Variations of greater than four percentage points are subject to review  
18 by the commissioner, and must be approved or denied within sixty days  
19 of submittal. A variation that is not denied within sixty days shall  
20 be deemed approved. The commissioner must provide to the carrier a  
21 detailed actuarial justification for any denial within thirty days of  
22 the denial.

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

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

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

35 (k) If the rate developed under this section varies the adjusted  
36 community rate for the factors listed in (a) of this subsection, the  
37 date for determining those factors must be no more than ninety days  
38 prior to the effective date of the health benefit plan.

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

4 (5)(a) Except as provided in this subsection and subsection (3)(g)  
5 of this section, requirements used by a contractor in determining  
6 whether to provide coverage to a small employer shall be applied  
7 uniformly among all small employers applying for coverage or receiving  
8 coverage from the carrier.

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

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

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

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

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

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

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

36 **Sec. 5.** RCW 48.46.020 and 1990 c 119 s 1 are each amended to read  
37 as follows:

1 As used in this chapter, the terms defined in this section shall  
2 have the meanings indicated unless the context indicates otherwise.

3 (1) "Health maintenance organization" means any organization  
4 receiving a certificate of registration by the commissioner under this  
5 chapter which provides comprehensive health care services to enrolled  
6 participants of such organization on a group practice per capita  
7 prepayment basis or on a prepaid individual practice plan, except for  
8 an enrolled participant's responsibility for copayments and/or  
9 deductibles, either directly or through contractual or other  
10 arrangements with other institutions, entities, or persons, and which  
11 qualifies as a health maintenance organization pursuant to RCW  
12 48.46.030 and 48.46.040.

13 (2) "Comprehensive health care services" means basic consultative,  
14 diagnostic, and therapeutic services rendered by licensed health  
15 professionals together with emergency and preventive care, inpatient  
16 hospital, outpatient and physician care, at a minimum, and any  
17 additional health care services offered by the health maintenance  
18 organization.

19 (3) "Enrolled participant" means a person who or group of persons  
20 which has entered into a contractual arrangement or on whose behalf a  
21 contractual arrangement has been entered into with a health maintenance  
22 organization to receive health care services.

23 (4) "Health professionals" means health care practitioners who are  
24 regulated by the state of Washington.

25 (5) "Health maintenance agreement" means an agreement for services  
26 between a health maintenance organization which is registered pursuant  
27 to the provisions of this chapter and enrolled participants of such  
28 organization which provides enrolled participants with comprehensive  
29 health services rendered to enrolled participants by health  
30 professionals, groups, facilities, and other personnel associated with  
31 the health maintenance organization.

32 (6) "Consumer" means any member, subscriber, enrollee, beneficiary,  
33 or other person entitled to health care services under terms of a  
34 health maintenance agreement, but not including health professionals,  
35 employees of health maintenance organizations, partners, or  
36 shareholders of stock corporations licensed as health maintenance  
37 organizations.

1 (7) "Meaningful role in policy making" means a procedure approved  
2 by the commissioner which provides consumers or elected representatives  
3 of consumers a means of submitting the views and recommendations of  
4 such consumers to the governing board of such organization coupled with  
5 reasonable assurance that the board will give regard to such views and  
6 recommendations.

7 (8) "Meaningful grievance procedure" means a procedure for  
8 investigation of consumer grievances in a timely manner aimed at mutual  
9 agreement for settlement according to procedures approved by the  
10 commissioner, and which may include arbitration procedures.

11 (9) "Provider" means any health professional, hospital, or other  
12 institution, organization, or person that furnishes any health care  
13 services and is licensed or otherwise authorized to furnish such  
14 services.

15 (10) "Department" means the state department of social and health  
16 services.

17 (11) "Commissioner" means the insurance commissioner.

18 (12) "Group practice" means a partnership, association,  
19 corporation, or other group of health professionals:

20 (a) The members of which may be individual health professionals,  
21 clinics, or both individuals and clinics who engage in the coordinated  
22 practice of their profession; and

23 (b) The members of which are compensated by a prearranged salary,  
24 or by capitation payment or drawing account that is based on the number  
25 of enrolled participants.

26 (13) "Individual practice health care plan" means an association of  
27 health professionals in private practice who associate for the purpose  
28 of providing prepaid comprehensive health care services on a fee-for-  
29 service or capitation basis.

30 (14) "Uncovered expenditures" means the costs to the health  
31 maintenance organization of health care services that are the  
32 obligation of the health maintenance organization for which an enrolled  
33 participant would also be liable in the event of the health maintenance  
34 organization's insolvency and for which no alternative arrangements  
35 have been made as provided herein. The term does not include  
36 expenditures for covered services when a provider has agreed not to  
37 bill the enrolled participant even though the provider is not paid by

1 the health maintenance organization, or for services that are  
2 guaranteed, insured, or assumed by a person or organization other than  
3 the health maintenance organization.

4 (15) "Copayment" means an amount specified in a subscriber  
5 agreement which is an obligation of an enrolled participant for a  
6 specific service which is not fully prepaid.

7 (16) "Deductible" means the amount an enrolled participant is  
8 responsible to pay out-of-pocket before the health maintenance  
9 organization begins to pay the costs associated with treatment.

10 (17) "Fully subordinated debt" means those debts that meet the  
11 requirements of RCW 48.46.235(3) and are recorded as equity.

12 (18) "Net worth" means the excess of total admitted assets as  
13 defined in RCW 48.12.010 over total liabilities but the liabilities  
14 shall not include fully subordinated debt.

15 (19) "Participating provider" means a provider as defined in  
16 subsection (9) of this section who contracts with the health  
17 maintenance organization or with its contractor or subcontractor and  
18 has agreed to provide health care services to enrolled participants  
19 with an expectation of receiving payment, other than copayment or  
20 deductible, directly or indirectly, from the health maintenance  
21 organization.

22 (20) "Carrier" means a health maintenance organization, an insurer,  
23 a health care services contractor, or other entity responsible for the  
24 payment of benefits or provision of services under a group or  
25 individual agreement.

26 (21) "Replacement coverage" means the benefits provided by a  
27 succeeding carrier.

28 (22) "Insolvent" or "insolvency" means that the organization has  
29 been declared insolvent and is placed under an order of liquidation by  
30 a court of competent jurisdiction.

31 (23) "Census date" means the date upon which a health maintenance  
32 organization offering coverage to a small employer must base rate  
33 calculations. For a small employer applying for a health benefit plan  
34 through a health maintenance organization other than its current health  
35 maintenance organization, the census date is the date that final group  
36 composition is received by the health maintenance organization. For a  
37 small employer that is renewing its health benefit plan through its

1 existing health maintenance organization, the census date is ninety  
2 days prior to the effective date of the renewal.

3 **Sec. 6.** RCW 48.46.066 and 2009 c 131 s 3 are each amended to read  
4 as follows:

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

18 (b) A health benefit plan offered under this subsection shall  
19 provide coverage for hospital expenses and services rendered by a  
20 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
21 to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.350,  
22 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and  
23 48.46.530.

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

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

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

36 (i) Geographic area;

37 (ii) Family size;

1 (iii) Age; and

2 (iv) Wellness activities.

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

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

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

16 (e) A discount for wellness activities shall be permitted to  
17 reflect actuarially justified differences in utilization or cost  
18 attributed to such programs. Up to a twenty percent variance may be  
19 allowed for small employers that develop and implement a wellness  
20 program or activities that directly improve employee wellness.  
21 Employers shall document program activities with the carrier and may,  
22 after three years of implementation, request a reduction in premiums  
23 based on improved employee health and wellness. While carriers may  
24 review the employer's claim history when making a determination  
25 regarding whether the employer's wellness program has improved employee  
26 health, the carrier may not use maternity or prevention services claims  
27 to deny the employer's request. Carriers may consider issues such as  
28 improved productivity or a reduction in absenteeism due to illness if  
29 submitted by the employer for consideration. Interested employers may  
30 also work with the carrier to develop a wellness program and a means to  
31 track improved employee health.

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

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

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

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

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

3 (g) On the census date, as defined in RCW 48.46.020, rating factors  
4 shall produce premiums for identical groups that differ only by the  
5 amounts attributable to plan design, and differences in census date  
6 between new and renewal groups, with the exception of discounts for  
7 health improvement programs.

8 (h) For the purposes of this section, a health benefit plan that  
9 contains a restricted network provision shall not be considered similar  
10 coverage to a health benefit plan that does not contain such a  
11 provision, provided that the restrictions of benefits to network  
12 providers result in substantial differences in claims costs. A carrier  
13 may develop its rates based on claims costs due to network provider  
14 reimbursement schedules or type of network. This subsection does not  
15 restrict or enhance the portability of benefits as provided in RCW  
16 48.43.015.

17 (i) Adjusted community rates established under this section shall  
18 pool the medical experience of all groups purchasing coverage,  
19 including the small group participants in the health insurance  
20 partnership established in RCW 70.47A.030. However, annual rate  
21 adjustments for each small group health benefit plan may vary by up to  
22 plus or minus four percentage points from the overall adjustment of a  
23 carrier's entire small group pool, such overall adjustment to be  
24 approved by the commissioner, upon a showing by the carrier, certified  
25 by a member of the American academy of actuaries that: (i) The  
26 variation is a result of deductible leverage, benefit design, or  
27 provider network characteristics; and (ii) for a rate renewal period,  
28 the projected weighted average of all small group benefit plans will  
29 have a revenue neutral effect on the carrier's small group pool.  
30 Variations of greater than four percentage points are subject to review  
31 by the commissioner, and must be approved or denied within sixty days  
32 of submittal. A variation that is not denied within sixty days shall  
33 be deemed approved. The commissioner must provide to the carrier a  
34 detailed actuarial justification for any denial within thirty days of  
35 the denial.

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

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

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

11 (k) If the rate developed under this section varies the adjusted  
12 community rate for the factors listed in (a) of this subsection, the  
13 date for determining those factors must be no more than ninety days  
14 prior to the effective date of the health benefit plan.

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

18 (5)(a) Except as provided in this subsection and subsection (3)(g)  
19 of this section, requirements used by a health maintenance organization  
20 in determining whether to provide coverage to a small employer shall be  
21 applied uniformly among all small employers applying for coverage or  
22 receiving coverage from the carrier.

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

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

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

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

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

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

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

15 **Sec. 7.** RCW 48.21.045 and 2009 c 131 s 1 are each amended to read  
16 as follows:

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

28 (b) A health benefit plan offered under this subsection shall  
29 provide coverage for hospital expenses and services rendered by a  
30 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
31 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,  
32 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,  
33 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250,  
34 48.21.300, 48.21.310, or 48.21.320.

35 (2) Nothing in this section shall prohibit an insurer from  
36 offering, or a purchaser from seeking, health benefit plans with  
37 benefits in excess of the health benefit plan offered under subsection

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

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

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

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

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

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

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

26 (e) A discount for wellness activities shall be permitted to  
27 reflect actuarially justified differences in utilization or cost  
28 attributed to such programs. Up to a twenty percent variance may be  
29 allowed for small employers that develop and implement a wellness  
30 program or activities that directly improve employee wellness.  
31 Employers shall document program activities with the carrier and may,  
32 after three years of implementation, request a reduction in premiums  
33 based on improved employee health and wellness. While carriers may  
34 review the employer's claim history when making a determination  
35 regarding whether the employer's wellness program has improved employee  
36 health, the carrier may not use maternity or prevention services claims  
37 to deny the employer's request. Carriers may consider issues such as  
38 improved productivity or a reduction in absenteeism due to illness if

1 submitted by the employer for consideration. Interested employers may  
2 also work with the carrier to develop a wellness program and a means to  
3 track improved employee health.

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

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

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

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

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

13 (g) On the census date, as defined in RCW 48.21.047, rating factors  
14 shall produce premiums for identical groups that differ only by the  
15 amounts attributable to plan design, and differences in census date  
16 between new and renewal groups, with the exception of discounts for  
17 health improvement programs.

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

27 (i) Adjusted community rates established under this section shall  
28 pool the medical experience of all small groups purchasing coverage,  
29 including the small group participants in the health insurance  
30 partnership established in RCW 70.47A.030. However, annual rate  
31 adjustments for each small group health benefit plan may vary by up to  
32 plus or minus four percentage points from the overall adjustment of a  
33 carrier's entire small group pool, such overall adjustment to be  
34 approved by the commissioner, upon a showing by the carrier, certified  
35 by a member of the American academy of actuaries that: (i) The  
36 variation is a result of deductible leverage, benefit design, or  
37 provider network characteristics; and (ii) for a rate renewal period,  
38 the projected weighted average of all small group benefit plans will

1 have a revenue neutral effect on the carrier's small group pool.  
2 Variations of greater than four percentage points are subject to review  
3 by the commissioner, and must be approved or denied within sixty days  
4 of submittal. A variation that is not denied within sixty days shall  
5 be deemed approved. The commissioner must provide to the carrier a  
6 detailed actuarial justification for any denial within thirty days of  
7 the denial.

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

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

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

20 (k) If the rate developed under this section varies the adjusted  
21 community rate for the factors listed in (a) of this subsection, the  
22 date for determining those factors must be no more than ninety days  
23 prior to the effective date of the health benefit plan.

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

27 (5)(a) Except as provided in this subsection and subsection (3)(g)  
28 of this section, requirements used by an insurer in determining whether  
29 to provide coverage to a small employer shall be applied uniformly  
30 among all small employers applying for coverage or receiving coverage  
31 from the carrier.

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

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

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

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

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

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

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

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

25 **Sec. 8.** RCW 48.21.047 and 2005 c 223 s 11 are each amended to read  
26 as follows:

27 (1) An insurer may not offer any health benefit plan to any small  
28 employer without complying with RCW 48.21.045(3).

29 (2) Employers purchasing health plans provided through associations  
30 or through member-governed groups formed specifically for the purpose  
31 of purchasing health care are not small employers and the plans are not  
32 subject to RCW 48.21.045(3).

33 (3) For purposes of this section, "health benefit plan," "health  
34 plan," and "small employer" mean the same as defined in RCW 48.43.005.

35 (4) For purposes of this section, "census date" has the same  
36 meaning as defined in RCW 48.44.010.

1        NEW\_SECTION.   **Sec. 9.** This act applies to policies issued or  
2 renewed on or after January 1, 2011.

3        NEW\_SECTION.   **Sec. 10.** If federal legislation that includes  
4 guaranteed issue for individuals who purchase health coverage through  
5 the individual or small group market has not been signed by the  
6 President of the United States by December 31, 2010, sections 1 and 2  
7 of this act are null and void.

8        NEW\_SECTION.   **Sec. 11.** Sections 1 and 2 of this act take effect  
9 one hundred eighty days after the date the insurance commissioner  
10 certifies to the secretary of the senate, the chief clerk of the house  
11 of representatives, and the code reviser's office that federal  
12 legislation has been signed into law by the President of the United  
13 States that includes guaranteed issue for individuals who purchase  
14 health coverage through the individual or small group markets.

Passed by the Senate March 10, 2010.

Passed by the House March 9, 2010.

Approved by the Governor April 1, 2010.

Filed in Office of Secretary of State April 2, 2010.