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**SUBSTITUTE HOUSE BILL 2997**

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

**By** House Health Care & Wellness (originally sponsored by Representatives Cody, Ericksen, Morrell, and Wallace)

READ FIRST TIME 02/02/10.

1            AN ACT Relating to determining the appropriate date of a small  
2 employer group's composition for purposes of setting health benefit  
3 plan premium rates; amending RCW 48.44.010, 48.44.023, 48.46.020,  
4 48.46.066, 48.21.045, and 48.21.047; and creating a new section.

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

6            **Sec. 1.** RCW 48.44.010 and 2007 c 267 s 2 are each amended to read  
7 as follows:

8            For the purposes of this chapter:

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

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

15            (3) "Health care service contractor" means any corporation,  
16 cooperative group, or association, which is sponsored by or otherwise  
17 intimately connected with a provider or group of providers, who or  
18 which not otherwise being engaged in the insurance business, accepts  
19 prepayment for health care services from or for the benefit of persons

1 or groups of persons as consideration for providing such persons with  
2 any health care services. "Health care service contractor" does not  
3 include direct patient-provider primary care practices as defined in  
4 RCW 48.150.010.

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

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

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

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

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

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

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

36 (11) "Individual contract" means a contract for health care  
37 services issued to and covering an individual. An individual contract  
38 may include dependents.

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

5 (13) "Replacement coverage" means the benefits provided by a  
6 succeeding carrier.

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

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

12 (16) "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 (17) "Census date" means the date upon which a health care services  
16 contractor offering coverage to a small employer must base rate  
17 calculations. For a small employer applying for a health benefit plan  
18 through a contractor other than its current contractor, the census date  
19 is the date that final group composition is received by the contractor.  
20 For a small employer that is renewing its health benefit plan through  
21 its existing contractor, the census date is ninety days prior to the  
22 effective date of the renewal.

23 **Sec. 2.** RCW 48.44.023 and 2009 c 131 s 2 are each amended to read  
24 as follows:

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

1 (b) A health benefit plan offered under this subsection shall  
2 provide coverage for hospital expenses and services rendered by a  
3 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
4 to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290,  
5 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335,  
6 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

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

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

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

- 18 (i) Geographic area;
- 19 (ii) Family size;
- 20 (iii) Age; and
- 21 (iv) Wellness activities.

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

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

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

35 (e) A discount for wellness activities shall be permitted to  
36 reflect actuarially justified differences in utilization or cost  
37 attributed to such programs. Up to a twenty percent variance may be  
38 allowed for small employers that develop and implement a wellness

1 program or activities that directly improve employee wellness.  
2 Employers shall document program activities with the carrier and may,  
3 after three years of implementation, request a reduction in premiums  
4 based on improved employee health and wellness. While carriers may  
5 review the employer's claim history when making a determination  
6 regarding whether the employer's wellness program has improved employee  
7 health, the carrier may not use maternity or prevention services claims  
8 to deny the employer's request. Carriers may consider issues such as  
9 improved productivity or a reduction in absenteeism due to illness if  
10 submitted by the employer for consideration. Interested employers may  
11 also work with the carrier to develop a wellness program and a means to  
12 track improved employee health.

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

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

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

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

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

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

27 (h) For the purposes of this section, a health benefit plan that  
28 contains a restricted network provision shall not be considered similar  
29 coverage to a health benefit plan that does not contain such a  
30 provision, provided that the restrictions of benefits to network  
31 providers result in substantial differences in claims costs. A carrier  
32 may develop its rates based on claims costs due to network provider  
33 reimbursement schedules or type of network. This subsection does not  
34 restrict or enhance the portability of benefits as provided in RCW  
35 48.43.015.

36 (i) Adjusted community rates established under this section shall  
37 pool the medical experience of all groups purchasing coverage,  
38 including the small group participants in the health insurance

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

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

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

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

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

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

36 (5)(a) Except as provided in this subsection and subsection (3)(g)  
37 of this section, requirements used by a contractor in determining

1 whether to provide coverage to a small employer shall be applied  
2 uniformly among all small employers applying for coverage or receiving  
3 coverage from the carrier.

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

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

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

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

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

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

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

31 **Sec. 3.** RCW 48.46.020 and 1990 c 119 s 1 are each amended to read  
32 as follows:

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

35 (1) "Health maintenance organization" means any organization  
36 receiving a certificate of registration by the commissioner under this  
37 chapter which provides comprehensive health care services to enrolled

1 participants of such organization on a group practice per capita  
2 prepayment basis or on a prepaid individual practice plan, except for  
3 an enrolled participant's responsibility for copayments and/or  
4 deductibles, either directly or through contractual or other  
5 arrangements with other institutions, entities, or persons, and which  
6 qualifies as a health maintenance organization pursuant to RCW  
7 48.46.030 and 48.46.040.

8 (2) "Comprehensive health care services" means basic consultative,  
9 diagnostic, and therapeutic services rendered by licensed health  
10 professionals together with emergency and preventive care, inpatient  
11 hospital, outpatient and physician care, at a minimum, and any  
12 additional health care services offered by the health maintenance  
13 organization.

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

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

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

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

33 (7) "Meaningful role in policy making" means a procedure approved  
34 by the commissioner which provides consumers or elected representatives  
35 of consumers a means of submitting the views and recommendations of  
36 such consumers to the governing board of such organization coupled with  
37 reasonable assurance that the board will give regard to such views and  
38 recommendations.



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

5 (9) "Provider" means any health professional, hospital, or other  
6 institution, organization, or person that furnishes any health care  
7 services and is licensed or otherwise authorized to furnish such  
8 services.

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

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

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

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

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

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

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

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

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

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

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

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

16 (20) "Carrier" means a health maintenance organization, an insurer,  
17 a health care services contractor, or other entity responsible for the  
18 payment of benefits or provision of services under a group or  
19 individual agreement.

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

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

25 (23) "Census date" means the date upon which a health maintenance  
26 organization offering coverage to a small employer must base rate  
27 calculations. For a small employer applying for a health benefit plan  
28 through a health maintenance organization other than its current health  
29 maintenance organization, the census date is the date that final group  
30 composition is received by the health maintenance organization. For a  
31 small employer that is renewing its health benefit plan through its  
32 existing health maintenance organization, the census date is ninety  
33 days prior to the effective date of the renewal.

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

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

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

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

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

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

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

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

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

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

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

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

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

- 29 (i) Changes to the enrollment of the small employer;
- 30 (ii) Changes to the family composition of the employee;
- 31 (iii) Changes to the health benefit plan requested by the small  
32 employer; or
- 33 (iv) Changes in government requirements affecting the health  
34 benefit plan.

35 (g) On the census date, as defined in RCW 48.46.020, rating factors  
36 shall produce premiums for identical groups that differ only by the  
37 amounts attributable to plan design, and differences in census date

1 between new and renewal groups, with the exception of discounts for  
2 health improvement programs.

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

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

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

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

36 (ii) Risk adjustment or reinsurance mechanisms may be used by the  
37 health insurance partnership program to redistribute funds to carriers  
38 participating in the health insurance partnership based on differences

1 in risk attributable to individual choice of health plans or other  
2 factors unique to health insurance partnership participation. Use of  
3 such mechanisms shall be limited to the partnership program and will  
4 not affect small group health plans offered outside the partnership.

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

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

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

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

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

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

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

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

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

37 (6) A health maintenance organization must offer coverage to all  
38 eligible employees of a small employer and their dependents. A health

1 maintenance organization may not offer coverage to only certain  
2 individuals or dependents in a small employer group or to only part of  
3 the group. A health maintenance organization may not modify a health  
4 plan with respect to a small employer or any eligible employee or  
5 dependent, through riders, endorsements or otherwise, to restrict or  
6 exclude coverage or benefits for specific diseases, medical conditions,  
7 or services otherwise covered by the plan.

8 **Sec. 5.** RCW 48.21.045 and 2009 c 131 s 1 are each amended to read  
9 as follows:

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

21 (b) A health benefit plan offered under this subsection shall  
22 provide coverage for hospital expenses and services rendered by a  
23 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
24 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,  
25 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,  
26 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.244, 48.21.250,  
27 48.21.300, 48.21.310, or 48.21.320.

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

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

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

- 3 (i) Geographic area;
- 4 (ii) Family size;
- 5 (iii) Age; and
- 6 (iv) Wellness activities.

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

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

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

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

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



1 (i) Changes to the enrollment of the small employer;  
2 (ii) Changes to the family composition of the employee;  
3 (iii) Changes to the health benefit plan requested by the small  
4 employer; or  
5 (iv) Changes in government requirements affecting the health  
6 benefit plan.

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

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

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

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

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

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

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

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

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

22 (5)(a) Except as provided in this subsection and subsection (3)(g)  
23 of this subsection, requirements used by an insurer in determining  
24 whether to provide coverage to a small employer shall be applied  
25 uniformly among all small employers applying for coverage or receiving  
26 coverage from the carrier.

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

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

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

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

37 (d) An insurer may not increase any requirement for minimum

1 employee participation or modify any requirement for minimum employer  
2 contribution applicable to a small employer at any time after the small  
3 employer has been accepted for coverage.

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

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

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

20 **Sec. 6.** RCW 48.21.047 and 2005 c 223 s 11 are each amended to read  
21 as follows:

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

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

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

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

32 NEW SECTION. **Sec. 7.** This act applies to policies issued on or  
33 after January 1, 2011.

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