H-1752.2

SUBSTITUTE HOUSE BILL 1569

State of Washington 60th Legislature 2007 Regular Session

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

READ FIRST TIME 02/12/07.

1 AN ACT Relating to reforming the health care system in Washington
2 state; amending RCW 41.05.021, 48.43.005, 48.43.015, 48.43.025,
3 48.43.035, 48.41.100, and 70.47.020; adding new sections to chapter
4 48.43 RCW; adding a new section to chapter 70.47 RCW; adding a new
5 chapter to Title 41 RCW; adding a new chapter to Title 49 RCW; creating
6 new sections; repealing RCW 48.21.045, 48.21.047, 48.44.023, 48.44.024,
7 48.46.066, 48.46.068, 70.47A.010, 70.47A.020, 70.47A.030, 70.47A.040,
8 70.47A.050, 70.47A.060, 70.47A.070, 70.47A.080, 70.47A.090, and
9 70.47A.900; and providing effective dates.

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

11 **PART I: FINDINGS AND INTENT**

12 NEW SECTION. **Sec. 101.** LEGISLATIVE FINDINGS. The legislature
13 finds that:
14 (1) The people of Washington have expressed strong concerns about
15 health care costs and access to needed health services. Even if
16 currently insured, they are not confident that they will continue to
17 have health insurance coverage in the future and feel that they are
18 getting less, but spending more.

(2) Many employers, especially small employers, struggle with the cost of providing employer-sponsored health insurance coverage to their employees, while others are unable to offer employer-sponsored health insurance due to its high cost.

(3) Six hundred thousand Washingtonians are uninsured. Three-quarters work or have a working family member; two-thirds are low income; and one-half are young adults. Many are low-wage workers who are not offered, or eligible for, employer-sponsored coverage. Others struggle with the burden of paying their share of the costs of employer-sponsored health insurance, while still others turn down their employer's offer of coverage due to its costs.

(4) Access to health insurance and other health care spending has resulted in improved health for many Washingtonians. Yet, we are not receiving as much value as we should for each health care dollar spent in Washington state. By failing to sufficiently focus our efforts on prevention and management of chronic diseases, such as diabetes, asthma, and heart disease, too many Washingtonians suffer from complications of their illnesses. By failing to make health insurance coverage affordable for low-wage workers and self-employed people, health problems that could be treated in a doctor's office are treated in the emergency room or hospital. By failing to focus on the most effective ways to maintain our health and treat disease, Washingtonians have not made lifestyle changes proven to improve health, nor do they receive the most effective care.

NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT. The legislature intends, through the public/private partnership reflected in this act, to improve our current health care system so that:

(1) Health insurance coverage is more affordable for employers, employees, self-employed people, and other individuals;

(2) The process of choosing and purchasing health insurance coverage is well-informed, clearer, and simpler;

(3) Prevention, chronic care management, wellness, and improved quality of care are a fundamental part of our health care system; and

(4) As a result of these changes, more people in Washington state have access to affordable health insurance coverage and health outcomes in Washington state are improved.

PART II: HEALTH INSURANCE CONNECTOR

NEW SECTION. **Sec. 201.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administrator" means the administrator of the health care authority as defined in RCW 41.05.011.

(2) "Authority" means the health care authority established in chapter 41.05 RCW.

(3) "Basic health plan" means the program administered under chapter 70.47 RCW.

(4) "Carrier" means a carrier as defined in RCW 48.43.005.

(5) "Commissioner" means the insurance commissioner established under RCW 48.02.010.

(6) "Connector" means the Washington state health insurance connector established in section 203 of this act.

(7) "Connector board" and "board" means the board of the Washington state health insurance connector established in section 204 of this act.

(8) "Connector participant" means a person who has been determined by the connector to be, and continues to be, an employee of a participating small employer plan for purposes of obtaining coverage through the connector or a former employee of a participating small employer plan who chooses to continue receiving coverage through the connector following separation from employment.

(9) "Eligible small group" or "eligible small employer" means a small group or small employer as defined in RCW 48.43.005.

(10) "Health plan" or "health benefit plan" means a health plan or health benefit plan as defined in RCW 48.43.005.

(11) "Participating small employer plan" means a group health plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186), that is sponsored by a small employer and for which the plan sponsor has entered into an agreement with the connector, in accordance with the provisions of section 207 of this act, for the connector to offer and administer health insurance benefits for enrollees in the plan.

(12) "Preexisting condition" means a preexisting condition as defined in RCW 48.43.005.

(13) "Premium assistance payment" means a payment made to carriers by the connector as provided in section 209 of this act.

1 **Sec. 202.** RCW 41.05.021 and 2006 c 103 s 2 are each amended to
2 read as follows:
3 (1) The Washington state health care authority is created within
4 the executive branch. The authority shall have an administrator
5 appointed by the governor, with the consent of the senate. The
6 administrator shall serve at the pleasure of the governor. The
7 administrator may employ up to seven staff members, who shall be exempt
8 from chapter 41.06 RCW, and any additional staff members as are
9 necessary to administer this chapter. The administrator may delegate
10 any power or duty vested in him or her by this chapter, including
11 authority to make final decisions and enter final orders in hearings
12 conducted under chapter 34.05 RCW. The primary duties of the authority
13 shall be to: Administer state employees' insurance benefits and
14 retired or disabled school employees' insurance benefits; administer
15 the basic health plan pursuant to chapter 70.47 RCW; study state-
16 purchased health care programs in order to maximize cost containment in
17 these programs while ensuring access to quality health care; and
18 implement state initiatives, joint purchasing strategies, and
19 techniques for efficient administration that have potential application
20 to all state-purchased health services. The authority's duties
21 include, but are not limited to, the following:
22 (a) To administer health care benefit programs for employees and
23 retired or disabled school employees as specifically authorized in RCW
24 41.05.065 and in accordance with the methods described in RCW
25 41.05.075, 41.05.140, and other provisions of this chapter;
26 (b) To analyze state-purchased health care programs and to explore
27 options for cost containment and delivery alternatives for those
28 programs that are consistent with the purposes of those programs,
29 including, but not limited to:
30 (i) Creation of economic incentives for the persons for whom the
31 state purchases health care to appropriately utilize and purchase
32 health care services, including the development of flexible benefit
33 plans to offset increases in individual financial responsibility;
34 (ii) Utilization of provider arrangements that encourage cost
35 containment, including but not limited to prepaid delivery systems,
36 utilization review, and prospective payment methods, and that ensure
37 access to quality care, including assuring reasonable access to local
38 providers, especially for employees residing in rural areas;

1 (iii) Coordination of state agency efforts to purchase drugs
2 effectively as provided in RCW 70.14.050;
3 (iv) Development of recommendations and methods for purchasing
4 medical equipment and supporting services on a volume discount basis;
5 (v) Development of data systems to obtain utilization data from
6 state-purchased health care programs in order to identify cost centers,
7 utilization patterns, provider and hospital practice patterns, and
8 procedure costs, utilizing the information obtained pursuant to RCW
9 41.05.031; and
10 (vi) In collaboration with other state agencies that administer
11 state purchased health care programs, private health care purchasers,
12 health care facilities, providers, and carriers:
13 (A) Use evidence-based medicine principles to develop common
14 performance measures and implement financial incentives in contracts
15 with insuring entities, health care facilities, and providers that:
16 (I) Reward improvements in health outcomes for individuals with
17 chronic diseases, increased utilization of appropriate preventive
18 health services, and reductions in medical errors; and
19 (II) Increase, through appropriate incentives to insuring entities,
20 health care facilities, and providers, the adoption and use of
21 information technology that contributes to improved health outcomes,
22 better coordination of care, and decreased medical errors;
23 (B) Through state health purchasing, reimbursement, or pilot
24 strategies, promote and increase the adoption of health information
25 technology systems, including electronic medical records, by hospitals
26 as defined in RCW 70.41.020(4), integrated delivery systems, and
27 providers that:
28 (I) Facilitate diagnosis or treatment;
29 (II) Reduce unnecessary duplication of medical tests;
30 (III) Promote efficient electronic physician order entry;
31 (IV) Increase access to health information for consumers and their
32 providers; and
33 (V) Improve health outcomes;
34 (C) Coordinate a strategy for the adoption of health information
35 technology systems using the final health information technology report
36 and recommendations developed under chapter 261, Laws of 2005((~~.~~))<u>;</u>
37 (c) To analyze areas of public and private health care interaction;

1 (d) To provide information and technical and administrative
2 assistance to the board;
3 (e) To review and approve or deny applications from counties,
4 municipalities, and other political subdivisions of the state to
5 provide state-sponsored insurance or self-insurance programs to their
6 employees in accordance with the provisions of RCW 41.04.205, setting
7 the premium contribution for approved groups as outlined in RCW
8 41.05.050;
9 (f) To establish billing procedures and collect funds from school
10 districts in a way that minimizes the administrative burden on
11 districts;
12 (g) To publish and distribute to nonparticipating school districts
13 and educational service districts by October 1st of each year a
14 description of health care benefit plans available through the
15 authority and the estimated cost if school districts and educational
16 service district employees were enrolled;
17 (h) To administer the Washington state health insurance connector
18 established in sections 203 through 205 of this act;
19 (i) To apply for, receive, and accept grants, gifts, and other
20 payments, including property and service, from any governmental or
21 other public or private entity or person, and make arrangements as to
22 the use of these receipts to implement initiatives and strategies
23 developed under this section; and
24 ((~~(i)~~)) (j) To promulgate and adopt rules consistent with this
25 chapter as described in RCW 41.05.160.
26 (2) On and after January 1, 1996, the public employees' benefits
27 board may implement strategies to promote managed competition among
28 employee health benefit plans. Strategies may include but are not
29 limited to:
30 (a) Standardizing the benefit package;
31 (b) Soliciting competitive bids for the benefit package;
32 (c) Limiting the state's contribution to a percent of the lowest
33 priced qualified plan within a geographical area;
34 (d) Monitoring the impact of the approach under this subsection
35 with regards to: Efficiencies in health service delivery, cost shifts
36 to subscribers, access to and choice of managed care plans statewide,
37 and quality of health services. The health care authority shall also

1 advise on the value of administering a benchmark employer-managed plan
2 to promote competition among managed care plans.

3 <u>NEW SECTION.</u> **Sec. 203.** (1) The Washington state health insurance
4 connector is hereby established. The connector shall be administered
5 by the administrator and governed by the Washington state health
6 insurance connector board established in section 204 of this act. The
7 purpose of the connector is to facilitate the availability, choice, and
8 adoption of private health insurance plans, as provided in this
9 chapter.
10 (2) With the approval of the board, the administrator, or his or
11 her designee, has the following powers and duties:
12 (a) Plan, direct, coordinate, and execute administrative functions
13 in conformity with the policies and directives of the board;
14 (b) Employ professional and clerical staff as necessary;
15 (c) Report to the board on all operations under his or her control
16 and supervision;
17 (d) Prepare an annual budget and manage the administrative expenses
18 of the connector; and
19 (e) Undertake any other activities necessary to implement the
20 powers and duties set forth in this chapter.

21 <u>NEW SECTION.</u> **Sec. 204.** (1) The Washington state health insurance
22 connector board is hereby established. The function of the board is to
23 develop and approve policies necessary for operation of the Washington
24 state health insurance connector.
25 (2) The connector board shall be composed of twelve members
26 appointed by the governor as follows:
27 (a) A member in good standing of the American academy of actuaries;
28 (b) Two representatives of small businesses;
29 (c) Two employee health plan benefits specialists;
30 (d) Two representatives of health care consumers;
31 (e) A physician licensed in good standing under chapter 18.57 RCW;
32 (f) A health insurance broker licensed in good standing under
33 chapter 48.17 RCW;
34 (g) The assistant secretary of the department of social and health
35 services, health recovery services administration;
36 (h) The commissioner; and

1 (i) The administrator.
2 (3) The governor shall appoint the initial members of the board to
3 staggered terms not to exceed four years. Members appointed thereafter
4 shall serve two-year terms. Members of the board shall be compensated
5 in accordance with RCW 43.03.250 and shall be reimbursed for their
6 travel expenses while on official business in accordance with RCW
7 43.03.050 and 43.03.060. The board shall prescribe rules for the
8 conduct of its business. The administrator shall serve as chair of the
9 board. Meetings of the board shall be at the call of the chair.
10 (4) The board may establish technical advisory committees or seek
11 the advice of technical experts when necessary to execute the powers
12 and duties included in section 205 of this act.

13 NEW SECTION. **Sec. 205.** The connector board has the following
14 duties and powers:
15 (1) Develop and approve a benefit design for health benefit plans
16 that will be sold by carriers as individual health plans through the
17 connector. The connector shall offer at least four, but no more than
18 six, benefit packages. For each benefit package, the board shall
19 develop at least three deductible and point-of-service cost-sharing
20 options.
21 (a) One benefit package shall include services comparable to those
22 offered through the basic health plan under chapter 70.47 RCW, as of
23 January 1, 2007. One of the deductible and cost-sharing options
24 offered with this benefit package shall be the deductible and
25 cost-sharing provisions of the basic health plan as of January 1, 2007.
26 In developing the remaining benefit packages and deductible and
27 cost-sharing options, the board shall provide a range of options, from
28 catastrophic to comprehensive coverage, so that a broad choice of
29 health plans is available to small employers and their employees.
30 (b) In designing the benefit packages, the board shall make every
31 effort to include innovative components that will maximize the quality
32 of care provided and result in improved health outcomes. These
33 components include, but are not limited to:
34 (i) Preventive care;
35 (ii) Wellness incentives, such as personal health assessments with
36 health coaching, and smoking cessation benefits;

1 (iii) Limited cost-sharing for preventive services, medications to
2 manage chronic illness, and chronic care management visits;
3 (iv) Payment for chronic care services, such as increased
4 reimbursement for primary care visits, reimbursement for care
5 coordination services, and coverage of group visits, telephone
6 consultation, and nutrition education that enable patients to learn the
7 skills needed to manage their chronic illness;
8 (v) Provider network development and payment policies related to
9 quality of care, such as tiered networks, payment for performance in
10 areas such as use of evidence-based protocols, delivery of preventive
11 and chronic care management services, and quality and outcomes
12 reporting.
13 (c) The board shall establish an advisory committee that includes
14 small employers, employees, low-wage workers, carriers, brokers, and
15 other stakeholders to provide advice and input related to the
16 development of benefit packages and deductible and cost-sharing
17 options.
18 (d) The board may design and approve a limited health care service
19 plan for dental care services to be offered by limited health care
20 service contractors under RCW 48.44.035;
21 (2) Establish enrollment procedures, including:
22 (a) Publicizing the existence of the connector and disseminating
23 information on eligibility requirements and enrollment procedures for
24 the connector;
25 (b) Establishing procedures to determine each applicant's
26 eligibility for purchasing insurance offered by the connector,
27 including a standard application form for persons seeking to purchase
28 health plans through the connector, as well as persons seeking a
29 premium assistance payment. The application shall include information
30 necessary to determine an applicant's eligibility, previous health
31 insurance coverage history, and payment method;
32 (c) Establishing rules related to minimum participation of
33 employees in small groups seeking to purchase health insurance through
34 the connector;
35 (d) Preparing and distributing certificate of eligibility forms and
36 application forms to insurance brokers and the general public; and
37 (e) Establishing and administering procedures for the election of
38 coverage by connector participants during open enrollment periods and

outside of open enrollment periods upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law. The procedures shall include preparing and distributing to connector participants:

(i) Descriptions of the coverage, benefits, limitations, copayments, and premiums for all participating plans; and

(ii) Forms and instructions for electing coverage and arranging payment for coverage;

(3) Establish and manage a system of collecting and transmitting to the applicable carriers all premium payments or contributions made by or on behalf of connector participants, including developing mechanisms to receive and process automatic payroll deductions for connector participants enrolled in small employer plans;

(4) Establish a risk adjustment mechanism for premiums paid to carriers;

(5) Establish and manage a system for determining eligibility for premium assistance payments and remitting premium assistance payments to the carriers, as provided in section 209 of this act;

(6) Establish a plan for operating a health insurance service center to provide information on the connector and manage connector enrollment, and for publicizing the existence of the connector and the connector's eligibility requirements and enrollment procedures;

(7) Establish, beginning January 1, 2012, and annually thereafter, a schedule to determine whether creditable coverage is affordable for residents of Washington state at varying income levels. The schedule shall be developed for purposes of implementing section 404 of this act. In developing the schedule, the board shall examine the percentage of household income that it is reasonable to ask Washington state residents to dedicate to the purchase of creditable coverage, based upon a family's income relative to varying percentages of the federal poverty level, as determined annually by the federal department of health and human services;

(8) Establish procedures necessary to integrate the individual health insurance market, Washington state health insurance pool established under chapter 48.41 RCW, the basic health plan established under chapter 70.47 RCW, the public employees' benefits board program established under chapter 41.05 RCW, and public school employees into the connector beginning January 1, 2012;

(9) Establish other procedures for operations of the connector, including but not limited to procedures to:

(a) Seek and receive any grant funding from the federal government, departments or agencies of the state, and private foundations;

(b) Contract with professional service firms as may be necessary in the board's judgment, and to fix their compensation;

(c) Contract with companies which provide third-party administrative and billing services for insurance products;

(d) Adopt bylaws for the regulation of its affairs and the conduct of its business;

(e) Sue and be sued in its own name, plead, and be impleaded;

(f) Establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered and appropriations from the state, and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the employee retirement income security act of 1974; and

(g) Enter into interdepartmental agreements with the office of the insurance commissioner, department of social and health services, and any other state agencies the board deems necessary to implement this chapter; and

(10) Begin offering health benefit plans under this act on January 1, 2009, following an open enrollment period that begins on September 1, 2008.

NEW SECTION. **Sec. 206.** HEALTH BENEFIT PLANS OFFERED THROUGH THE CONNECTOR. (1) The connector shall not sponsor any health benefit plan, or contract with any carrier to offer any health benefit plan, that has not first been certified by the commissioner in accordance with section 301 of this act.

(2)(a) Except as provided in (b) of this subsection, no carrier may offer a health plan through the connector unless the carrier has agreed to offer all of the health plan options approved by the connector board under section 205(1) of this act.

(b) A carrier that has contracted exclusively with the department of social and health services to serve medicaid program clients, or with the authority to serve basic health plan enrollees, may offer only

the health plan comparable to the basic health plan under section 205(1)(a) of this act and may offer coverage only to persons receiving premium assistance under section 209 of this act.

NEW SECTION. **Sec. 207.** PARTICIPATING SMALL EMPLOYER PLANS. (1) Any small employer may apply to the connector to be the sponsor of a participating small employer plan.

(2) Any small employer seeking to be the sponsor of a participating small employer plan shall, as a condition of participation in the connector, enter into a binding agreement with the connector that includes the following conditions:

(a) The sponsoring small employer designates the connector to be the plan's administrator for the employer's group health plan, and the connector agrees to undertake the obligations required of a plan administrator under federal law;

(b) Any individual eligible to participate in the connector by reason of his or her eligibility for coverage under the employer's participating small employer plan may elect coverage under any health plan offered through the connector, and neither the employer nor the connector shall limit such individual's choice of coverage from among all the health plans offered;

(c) The small employer agrees that, for the term of the agreement, the small employer will not offer to individuals eligible to participate in the connector by reason of their eligibility for coverage under the employer's participating small employer plan any separate or competing health plan;

(d) The small employer reserves the right to determine the criteria for eligibility and enrollment in the participating small employer plan and the terms and amounts of the small employer's contributions to that plan, so long as for the term of the agreement with the connector the small employer agrees not to alter or amend any criteria or contribution amounts at any time other than during an annual period designated by the connector for participating small employer plans to make such changes in conjunction with the connector's annual open enrollment period;

(e) The small employer agrees to make available to the connector any of the employer's documents, records, or information, including

copies of the employer's federal and state tax and wage reports, that the administrator reasonably determines are necessary for the connector to verify:

(i) That the small employer is in compliance with the terms of its agreement with the connector governing the employer's sponsorship of a participating small employer plan;

(ii) That the participating small employer plan is in compliance with applicable laws relating to employee welfare benefit plans, particularly those relating to nondiscrimination in coverage; and

(iii) The eligibility, under the terms of the small employer's plan, of those individuals enrolled in the participating small employer plan;

(f) The small employer agrees to also sponsor a "cafeteria plan" as permitted under federal law, 26 U.S.C. Sec. 125, for all employees eligible for coverage under the employer's participating employer plan.

NEW SECTION. **Sec. 208.** ENROLLMENT AND COVERAGE ELECTION. Employees of any participating small employer plan may enroll in a health plan offered through the connector during an open enrollment period or, outside of open enrollment periods, upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law. Any former employee of a participating small employer plan who chooses to continue receiving coverage through the connector following separation from employment may continue his or her enrollment in a health plan offered through the connector, and may change health plans during an open enrollment period or, outside of open enrollment periods, upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law. The initial open enrollment period is September 1, 2008, through November 30, 2008.

NEW SECTION. **Sec. 209.** CONNECTOR PREMIUM ASSISTANCE PROGRAM. (1) The connector shall administer the connector premium assistance program established in this section and remit premium assistance payments to carriers offering health plans through the connector.

(2) Beginning January 1, 2009, the administrator shall accept applications for premium assistance from connector participants who

have family income up to two hundred percent of the federal poverty level, as determined annually by the federal department of health and human services, on behalf of themselves, their spouses, and their dependent children.

(3) The connector board shall design and implement a schedule of premium assistance payments that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The benchmark plan for purposes of designing the premium assistance payment schedule shall be the benefit design comparable to the basic health plan established under section 205(1)(a) of this act with the deductible and cost-sharing of the basic health plan benefit package in effect on January 1, 2007.

For employees of participating small employer plans, the premium assistance schedule shall be applied to the employee premium obligation remaining after employer premium contributions, so that employees benefit financially from their employer's contribution to the cost of their coverage through the connector. Any surcharge included in the premium under section 212 of this act shall be included when determining the appropriate level of premium assistance payments.

(4) A financial sponsor may, with the prior approval of the administrator, pay the premium or any other amount on behalf of a connector participant, by arrangement with the participant and through a mechanism acceptable to the administrator.

(5) The connector shall remit the premium assistance in an amount determined under subsection (3) of this section to the carrier offering the health plan in which the connector participant has chosen to enroll. If, however, such connector participant has chosen to enroll in a high deductible health plan, any difference between the amount of premium assistance that the participant would receive and the applicable premium rate for the high deductible health plan shall be deposited into a health savings account for the benefit of that participant.

NEW SECTION. **Sec. 210.** CONNECTOR PREMIUM ASSISTANCE ACCOUNT. The connector premium assistance account is hereby established in the custody of the state treasurer. Any nongeneral fund--state funds collected for the connector premium assistance program shall be deposited in the connector premium assistance account. Moneys in the

1 account shall be used exclusively for the purposes of administering the
2 connector premium assistance account, including payments to carriers on
3 behalf of connector participants. Only the administrator or his or her
4 designee may authorize expenditures from the account. The account is
5 subject to allotment procedures under chapter 43.88 RCW, but an
6 appropriation is not required for expenditures.

7 NEW SECTION. **Sec. 211.** BROKER COMMISSIONS. When an eligible
8 small group is enrolled in the connector by a health insurance broker
9 or solicitor licensed under chapter 48.17 RCW or by an association or
10 member-governed group, the connector shall pay the broker or
11 association or member-governed group a commission determined by the
12 connector board. In setting the commission, the connector board shall
13 consider rates of commissions paid to brokers for health plans issued
14 under chapters 48.21, 48.44, and 48.46 RCW as of January 1, 2007.

15 NEW SECTION. **Sec. 212.** SURCHARGE FOR CONNECTOR EXPENSES. (1) The
16 connector is authorized to apply a surcharge to all health benefit
17 plans, which shall be used only to pay for administrative and
18 operational expenses of the connector. Such a surcharge shall be
19 applied uniformly to all health benefit plans offered through the
20 connector and shall be included in the premium for each health plan.
21 As part of the premium, the surcharge shall be subject to the premium
22 tax under RCW 48.14.020. These surcharges shall not be used to pay any
23 premium assistance payments under this chapter.
24 (2) Each carrier participating in the connector shall be required
25 to furnish such reasonable reports as the board determines necessary to
26 enable the executive director to carry out his or her duties under this
27 chapter.

28 NEW SECTION. **Sec. 213.** FINANCIAL REPORT. The connector shall
29 keep an accurate account of all its activities and of all its receipts
30 and expenditures and shall annually make a report as of the end of its
31 fiscal year to its board, to the governor, and to the legislature, such
32 reports to be in a form prescribed by the board. The board may
33 investigate the affairs of the connector, may severally examine the
34 properties and records of the connector, and may prescribe methods of

accounting and the rendering of periodical reports in relation to projects undertaken by the connector. The connector shall be subject to biennial audit by the state auditor.

NEW SECTION. **Sec. 214.** REPORTS. No later than two years after the connector begins operation and every year thereafter, the connector shall conduct a study of the connector and the persons enrolled in the connector and shall submit a written report to the governor and the legislature on the status and activities of the connector based on data collected in the study. The report shall also be available to the general public. The study shall review:

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

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

NEW SECTION. **Sec. 215.** REPORT ON STATE AND SCHOOL EMPLOYEE PARTICIPATION IN THE CONNECTOR. On or before September 1, 2010, the board shall prepare a report and recommendations regarding the implementation of active and retired state employees' and public school employees' participation in the connector beginning January 1, 2012. The report shall be submitted to the governor and relevant committees of the legislature. The report shall examine at least the following issues:

(1) The impact of active and retired state employees and public school employees participating in the connector, with respect to the utilization of services and cost of health plans offered through the connector;

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

(3) The impact of applying the insurance regulations in section 303 of this act, RCW 48.43.015, 48.43.025, 48.43.035, and section 307 of this act on access to health services and the cost of coverage for active and retired state employees and public school employees; and

(4) How the composition of the board should be modified to reflect the participation of active and retired state employees and public school employees.

NEW SECTION. **Sec. 216.** RULES. The administrator may adopt any rules necessary to implement this chapter.

PART III: INSURANCE REGULATION OF HEALTH BENEFIT PLANS OFFERED THROUGH THE CONNECTOR

Sec. 301. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand dollars; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least five thousand five hundred dollars; or

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

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

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

(8) "Connector" means the Washington state health insurance connector established in sections 203 through 205 of this act.

(9) "Connector participant" means a person who has been determined by the connector to be, and continues to be, an employee of a participating small employer plan for purposes of obtaining coverage through the connector or a former employee of a participating small employer plan who chooses to continue receiving coverage through the connector following separation from employment.

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

((~~(9)~~)) (11) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

((~~(10)~~)) (12) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor,

if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

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

((~~(12)~~)) (14) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(13)~~)) (15) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(14)~~)) (16) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(15)~~)) (17) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers

licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

((~~(16)~~)) (18) "Health care provider" or "provider" means:

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

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

((~~(17)~~)) (19) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

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

((~~(19)~~)) (21) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(j) Employer-sponsored self-funded health plans;

(k) Dental only and vision only coverage; and

(l) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(20)~~)) (22) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(21)~~)) (23) "Participating small employer plan" means a group health plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186), that is sponsored by a small employer and for which the plan sponsor has entered into an agreement with the connector, in accordance with the provisions of section 207 of this act, for the connector to offer and administer health insurance benefits for enrollees in the plan.

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

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

((~~(23)~~)) (26) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(24)~~)) (27) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

((~~(25)~~)) (28) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(26)~~)) (29) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 302.** CERTIFICATION OF HEALTH BENEFIT PLANS BY THE OFFICE OF THE INSURANCE COMMISSIONER. (1) Health benefit plans offered through the connector established in section 203 of this act shall be filed with the office of the insurance commissioner.

(2) No health benefit plan may be offered through the connector unless the commissioner has first certified to the connector that:

(a) The carrier seeking to offer the plan is an admitted carrier in Washington state and is in good standing with the office of the insurance commissioner;

(b) The plan meets the benefit design specifications established by the connector board under section 205(1) of this act, the rating specifications under section 303 of this act, the preexisting condition provisions under RCW 48.43.015 and 48.43.025, the issue and renewal provisions of RCW 48.43.035, and the requirements of this section; and

(c) The plan and the carrier are in compliance with all other applicable Washington state laws.

(3) No plan shall be certified that excludes from coverage any individual otherwise determined by the connector as meeting the eligibility requirements for participation.

(4) Each certification shall be valid for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of either:

(a) Withdrawal by the commissioner; or

(b) Discontinuation of participation in the connector by the carrier.

(5) Certification of a plan may be withdrawn only after notice to the carrier and opportunity for hearing. The commissioner may, however, decline to renew the certification of any carrier at the end of a certification term.

(6) Each plan certified by the commissioner as eligible to be offered through the connector shall contain a detailed description of benefits offered including maximums, limitations, exclusions, and other benefit limits.

(7) Any limited health care services plan for dental care services offered through the connector established in section 203 of this act shall be filed with the office of the insurance commissioner. No limited health care services plan for dental care services may be offered through the connector unless the commissioner has first certified to the connector that the plan meets the benefit design specifications established by the connector board under section 205(1) of this act, and complies with subsections (2)(a) and (c), (3), and (6) of this section. Certification and withdrawal thereof shall be governed by subsections (4) and (5) of this section.

NEW SECTION. **Sec. 303.** HEALTH PLAN RATING METHODOLOGY. Premium rates for health benefit plans sold through the connector are subject to the following provisions:

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

(a) Geographic area;

(b) Family size;

(c) Age; and

(d) Wellness activities.

(2) The adjustment for age in subsection (1)(c) of this section may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Participating individuals under the age of twenty shall be treated as those age twenty.

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

(4) The permitted rates for any age group shall be no more than three hundred seventy-five percent of the lowest rate for all age groups.

(5) A discount for wellness activities is permitted to reflect

actuarially justified differences in utilization or cost attributed to such programs.

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

(7)(a) Except to the extent provided otherwise in (b) of this subsection, adjusted community rates established under this section shall pool the medical experience of all connector participants purchasing coverage through the connector.

(b) Carriers may treat persons under age thirty as a separate experience pool for purposes of establishing rates for health plans approved by the connector board under section 205(1)(a). The rates charged for this age group are not subject to subsection (4) of this section.

Sec. 304. RCW 48.43.015 and 2004 c 192 s 5 are each amended to read as follows:

(1) For a health benefit plan offered to a group <u>or through the connector established in sections 203 through 205 of this act</u>, every health carrier shall reduce any preexisting condition exclusion, limitation, or waiting period in the group health plan in accordance with the provisions of section 2701 of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg).

(2) For a health benefit plan offered to a group other than a small group:

(a) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for at least three months, then the carrier shall not impose a waiting period for coverage of preexisting conditions under the new health plan.

(b) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for less than three months, then the carrier shall credit the time covered under the immediately

1 preceding health plan toward any preexisting condition waiting period
2 under the new health plan.
3 (c) For the purposes of this subsection, a preceding health plan
4 includes an employer-provided self-funded health plan, the basic health
5 plan's offering to health coverage tax credit eligible enrollees as
6 established by chapter 192, Laws of 2004, and plans of the Washington
7 state health insurance pool.
8 (3) For a health benefit plan offered ((~~to a small group~~)) through
9 the connector established in sections 203 through 205 of this act:
10 (a) If the individual applicant's immediately preceding health plan
11 coverage terminated during the period beginning ninety days and ending
12 sixty-four days before the date of application for the new plan and
13 such coverage was similar and continuous for at least nine months, then
14 the carrier shall not impose a waiting period for coverage of
15 preexisting conditions under the new health plan.
16 (b) If the individual applicant's immediately preceding health plan
17 coverage terminated during the period beginning ninety days and ending
18 sixty-four days before the date of application for the new plan and
19 such coverage was similar and continuous for less than nine months,
20 then the carrier shall credit the time covered under the immediately
21 preceding health plan toward any preexisting condition waiting period
22 under the new health plan.
23 (c) For the purpose of this subsection, a preceding health plan
24 includes an employer-provided self-funded health plan, the basic health
25 plan's offering to health coverage tax credit eligible enrollees as
26 established by chapter 192, Laws of 2004, and plans of the Washington
27 state health insurance pool.
28 (4) For a health benefit plan offered to an individual, other than
29 an individual to whom subsection (5) of this section applies, every
30 health carrier shall credit any preexisting condition waiting period in
31 that plan for a person who was enrolled at any time during the sixty-
32 three day period immediately preceding the date of application for the
33 new health plan in a group health benefit plan or an individual health
34 benefit plan, other than a catastrophic health plan, and (a) the
35 benefits under the previous plan provide equivalent or greater overall
36 benefit coverage than that provided in the health benefit plan the
37 individual seeks to purchase; or (b) the person is seeking an
38 individual health benefit plan due to his or her change of residence

1 from one geographic area in Washington state to another geographic area
2 in Washington state where his or her current health plan is not
3 offered, if application for coverage is made within ninety days of
4 relocation; or (c) the person is seeking an individual health benefit
5 plan: (i) Because a health care provider with whom he or she has an
6 established care relationship and from whom he or she has received
7 treatment within the past twelve months is no longer part of the
8 carrier's provider network under his or her existing Washington
9 individual health benefit plan; and (ii) his or her health care
10 provider is part of another carrier's provider network; and (iii)
11 application for a health benefit plan under that carrier's provider
12 network individual coverage is made within ninety days of his or her
13 provider leaving the previous carrier's provider network. The carrier
14 must credit the period of coverage the person was continuously covered
15 under the immediately preceding health plan toward the waiting period
16 of the new health plan. For the purposes of this subsection (4), a
17 preceding health plan includes an employer-provided self-funded health
18 plan, the basic health plan's offering to health coverage tax credit
19 eligible enrollees as established by chapter 192, Laws of 2004, and
20 plans of the Washington state health insurance pool.
21 (5) Every health carrier shall waive any preexisting condition
22 waiting period in its individual plans for a person who is an eligible
23 individual as defined in section 2741(b) of the federal health
24 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
25 300gg-41(b)).
26 (6) Subject to the provisions of subsections (1) through (5) of
27 this section, nothing contained in this section requires a health
28 carrier to amend a health plan to provide new benefits in its existing
29 health plans. In addition, nothing in this section requires a carrier
30 to waive benefit limitations not related to an individual or group's
31 preexisting conditions or health history.

32 **Sec. 305.** RCW 48.43.025 and 2001 c 196 s 9 are each amended to
33 read as follows:
34 (1) For group health benefit plans for groups other than small
35 groups, no carrier may reject an individual for health plan coverage
36 based upon preexisting conditions of the individual and no carrier may
37 deny, exclude, or otherwise limit coverage for an individual's

preexisting health conditions; except that a carrier may impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

(2) For group health benefit plans ((~~for small groups~~)) offered through the connector established in sections 203 through 205 of this act, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions. Except that a carrier may impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within six months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

(3) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals or groups who are higher than average health risks. These provisions apply only to individuals who are Washington residents.

Sec. 306. RCW 48.43.035 and 2004 c 244 s 4 are each amended to read as follows:

For group health benefit plans and for health benefit plans offered through the connector established in sections 203 through 205 of this act, the following shall apply:

(1) All health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and within the carrier's service area and provide or assure the provision of all

1 covered services regardless of age, sex, family structure, ethnicity,
2 race, health condition, geographic location, employment status,
3 socioeconomic status, other condition or situation, or the provisions
4 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
5 exemption from this subsection, if, upon application by a health
6 carrier the commissioner finds that the clinical, financial, or
7 administrative capacity to serve existing enrollees will be impaired if
8 a health carrier is required to continue enrollment of additional
9 eligible individuals.

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

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

21 (a) Nonpayment of premium;

22 (b) Violation of published policies of the carrier approved by the
23 insurance commissioner;

24 (c) Covered persons entitled to become eligible for medicare
25 benefits by reason of age who fail to apply for a medicare supplement
26 plan or medicare cost, risk, or other plan offered by the carrier
27 pursuant to federal laws and regulations;

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

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

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

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

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

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

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

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

(d) A carrier discontinues offering all health coverage in the small group market or for groups of up to two hundred, or both markets, in the state and discontinues coverage under all existing group health benefit plans in the applicable market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any group health coverage in this state in the applicable group market involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the

commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

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

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

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

NEW SECTION. **Sec. 307.** INSURANCE MARKET CONSOLIDATION. A carrier shall not issue or renew a small group health benefit plan, including a plan offered through an association or member-governed group whether or not formed specifically for the purpose of purchasing health care, other than through the connector established in section 203 of this act, after January 1, 2009.

NEW SECTION. **Sec. 308.** RULES. The commissioner may adopt any rules necessary to implement this chapter.

PART IV: INDIVIDUAL AND EMPLOYER RESPONSIBILITY

NEW SECTION. **Sec. 401.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Employee" means any individual employed by any employer.

(2) "Employer" means an employer as defined in RCW 49.46.010.

(3) "Connector" means the entity established in sections 203 through 205 of this act.

1 NEW SECTION. **Sec. 402.** Beginning January 1, 2009, each employer
2 with more than five employees in the state of Washington shall:
3 (1) Adopt and maintain a cafeteria plan that satisfies 26 U.S.C.
4 Sec. 125 and the rules adopted by the connector that provides a premium
5 only plan option so that employees can use salary deductions to pay
6 health plan premiums. A copy of such cafeteria plan shall be filed
7 with the connector; and
8 (2) Collect and transmit amounts designated as payroll deductions
9 by employees to the connector for those employees purchasing coverage
10 through the connector.

11 NEW SECTION. **Sec. 403.** The attorney general shall enforce
12 sections 401 and 402 of this act and has the authority to seek and
13 obtain injunctive relief in a court of appropriate jurisdiction.

14 NEW SECTION. **Sec. 404.** Beginning January 1, 2012, any resident of
15 the state of Washington age eighteen and over shall obtain and maintain
16 creditable coverage, as defined in the federal health insurance
17 portability and accountability act of 1996 (42 U.S.C. 300gg(c)), so
18 long as it is deemed affordable under the schedule set by the board of
19 the connector under section 205 of this act. Residents who within the
20 past sixty-three days have terminated any prior creditable coverage,
21 shall obtain and maintain creditable coverage within sixty-three days
22 of such termination.

23 **PART V: NONSUBSIDIZED ENROLLMENT IN THE BASIC HEALTH PLAN**

24 **Sec. 501.** RCW 48.41.100 and 2001 c 196 s 3 are each amended to
25 read as follows:
26 (1) The following persons who are residents of this state are
27 eligible for pool coverage:
28 (a) Any person who provides evidence of a carrier's decision not to
29 accept him or her for enrollment in an individual health benefit plan
30 as defined in RCW 48.43.005, or of the health care authority
31 administrator's decision not to accept him or her for enrollment in the
32 basic health plan as a nonsubsidized enrollee, based upon, and within
33 ninety days of the receipt of, the results of the standard health

questionnaire designated by the board and administered by health carriers under RCW 48.43.018 or the administrator of the health care authority under section 503 of this act;

(b) Any person who continues to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator pursuant to subsection (3) of this section;

(c) Any person who resides in a county of the state where no carrier or insurer eligible under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool, and who makes direct application to the pool; and

(d) Any medicare eligible person upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on a medicare supplemental insurance policy under chapter 48.66 RCW, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(b) Any person on whose behalf the pool has paid out one million dollars in benefits;

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(d) Any person who resides in a county of the state where any carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic

health plan as defined in RCW 48.43.005 at the time of application to the pool and who does not qualify for pool coverage based upon the results of the standard health questionnaire, or pursuant to subsection (1)(d) of this section.

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county where no carrier had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in a pool plan pursuant to subsection (1)(c) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(c) of this section, but may continue to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator. The pool administrator shall offer to administer the questionnaire to each person no longer eligible for coverage under subsection (1)(c) of this section within thirty days of determining that he or she is no longer eligible;

(b) Losing eligibility for pool coverage under this subsection (3) does not affect a person's eligibility for pool coverage under subsection (1)(a), (b), or (d) of this section; and

(c) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options, either in or outside of the pool, available to the person; (iii) describe the procedures for the administration of the standard health questionnaire to determine the person's continued eligibility for coverage under subsection (1)(b) of this section; and (iv) describe the enrollment process for the available options outside of the pool.

Sec. 502. RCW 70.47.020 and 2005 c 188 s 2 are each amended to read as follows:

As used in this chapter:

(1) "Washington basic health plan" or "plan" means the system of

1 enrollment and payment for basic health care services, administered by
2 the plan administrator through participating managed health care
3 systems, created by this chapter.

4 (2) "Administrator" means the Washington basic health plan
5 administrator, who also holds the position of administrator of the
6 Washington state health care authority.

7 (3) "Health coverage tax credit program" means the program created
8 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
9 credit that subsidizes private health insurance coverage for displaced
10 workers certified to receive certain trade adjustment assistance
11 benefits and for individuals receiving benefits from the pension
12 benefit guaranty corporation.

13 (4) "Health coverage tax credit eligible enrollee" means individual
14 workers and their qualified family members who lose their jobs due to
15 the effects of international trade and are eligible for certain trade
16 adjustment assistance benefits; or are eligible for benefits under the
17 alternative trade adjustment assistance program; or are people who
18 receive benefits from the pension benefit guaranty corporation and are
19 at least fifty-five years old.

20 (5) "Managed health care system" means: (a) Any health care
21 organization, including health care providers, insurers, health care
22 service contractors, health maintenance organizations, or any
23 combination thereof, that provides directly or by contract basic health
24 care services, as defined by the administrator and rendered by duly
25 licensed providers, to a defined patient population enrolled in the
26 plan and in the managed health care system; or (b) a self-funded or
27 self-insured method of providing insurance coverage to subsidized
28 enrollees provided under RCW 41.05.140 and subject to the limitations
29 under RCW 70.47.100(7).

30 (6) "Subsidized enrollee" means an individual, or an individual
31 plus the individual's spouse or dependent children: (a) Who is not
32 eligible for medicare; (b) who is not confined or residing in a
33 government-operated institution, unless he or she meets eligibility
34 criteria adopted by the administrator; (c) who is not a full-time
35 student who has received a temporary visa to study in the United
36 States; (d) who resides in an area of the state served by a managed
37 health care system participating in the plan; (e) whose gross family
38 income at the time of enrollment does not exceed two hundred percent of

the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and (f) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan. To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual, or an individual's spouse or dependent children, who meets the requirements in (a) through (d) and (f) of this subsection and whose gross family income at the time of enrollment is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services.

(7) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who, under section 503 of this act, is not required to complete the standard health questionnaire or does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (d) who resides in an area of the state served by a managed health care system participating in the plan; ((~~(d)~~)) (e) who chooses to obtain basic health care coverage from a particular managed health care system; and ((~~(e)~~)) (f) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(8) "Subsidy" means the difference between the amount of periodic payment the administrator makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

(9) "Premium" means a periodic payment, based upon gross family income which an individual, their employer or another financial sponsor makes to the plan as consideration for enrollment in the plan as a subsidized enrollee, a nonsubsidized enrollee, or a health coverage tax credit eligible enrollee.

1 (10) "Rate" means the amount, negotiated by the administrator with
2 and paid to a participating managed health care system, that is based
3 upon the enrollment of subsidized, nonsubsidized, and health coverage
4 tax credit eligible enrollees in the plan and in that system.

5 NEW SECTION. **Sec. 503.** A new section is added to chapter 70.47
6 RCW to read as follows:
7 (1) Except as provided in (a) through (e) of this subsection, the
8 administrator shall require any person seeking enrollment in the basic
9 health plan as a nonsubsidized enrollee to complete the standard health
10 questionnaire designated under chapter 48.41 RCW.
11 (a) If a person is seeking enrollment in the basic health plan as
12 a nonsubsidized enrollee due to his or her change of residence from one
13 geographic area in Washington state to another geographic area in
14 Washington state where his or her current health plan is not offered,
15 completion of the standard health questionnaire shall not be a
16 condition of coverage if application for coverage is made within ninety
17 days of relocation.
18 (b) Completion of the standard health questionnaire shall not be a
19 condition of coverage if a person is seeking enrollment in the basic
20 health plan as a nonsubsidized enrollee:
21 (i) Because a health care provider with whom he or she has an
22 established care relationship and from whom he or she has received
23 treatment within the past twelve months is no longer part of the
24 provider network under his or her existing Washington individual health
25 benefit plan; and
26 (ii) His or her health care provider is part of a managed health
27 care system's provider network; and
28 (iii) Application for enrollment in the basic health plan as a
29 nonsubsidized enrollee under that managed health care system's provider
30 network is made within ninety days of his or her provider leaving the
31 previous carrier's provider network.
32 (c) If a person is seeking enrollment in the basic health plan as
33 a nonsubsidized enrollee due to his or her having exhausted
34 continuation coverage provided under 29 U.S.C. Sec. 1161 et seq.,
35 completion of the standard health questionnaire shall not be a
36 condition of coverage if application for coverage is made within ninety
37 days of exhaustion of continuation coverage. The administrator shall

accept an application without a standard health questionnaire from a person currently covered by such continuation coverage if application is made within ninety days prior to the date the continuation coverage would be exhausted and the effective date of the basic health plan coverage applied for is the date the continuation coverage would be exhausted, or within ninety days thereafter.

(d) If a person is seeking enrollment in the basic health plan as a nonsubsidized enrollee due to his or her receiving notice that his or her coverage under a conversion contract is discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. The administrator shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility under the conversion contract would be discontinued and the effective date of the basic health plan coverage applied for is the date eligibility under the conversion contract would be discontinued, or within ninety days thereafter.

(e) If a person is seeking enrollment in the basic health plan as a nonsubsidized enrollee and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. The administrator shall accept an application without a standard health questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the basic health plan coverage applied for is the date of the qualifying event, or within ninety days thereafter.

(2) If, based upon the results of the standard health questionnaire, the person qualifies for coverage under the Washington state health insurance pool, the following apply:

(a) The administrator shall not accept the person's application for enrollment in the basic health plan as a nonsubsidized enrollee; and

1 (b) Within fifteen business days of receipt of a completed
2 application, the administrator shall provide written notice of the
3 decision not to accept the person's application for enrollment in the
4 basic health plan as a nonsubsidized enrollee to both the person and
5 the administrator of the Washington state health insurance pool. The
6 notice to the person shall state that the person is eligible for health
7 insurance provided by the Washington state health insurance pool and
8 shall include information about the Washington state health insurance
9 pool and an application for such coverage. If the administrator does
10 not provide or postmark such notice within fifteen business days, the
11 application for enrollment in the basic health plan as a nonsubsidized
12 enrollee is deemed approved.

13 **PART VI: CONFORMING AMENDMENTS, REPEALERS, AND**
14 **EFFECTIVE DATES**

15 NEW SECTION. **Sec. 601.** (1) Sections 102, 201, and 203 through 216
16 of this act constitute a new chapter in Title 41 RCW.
17 (2) Sections 302, 303, 307, and 308 of this act are each added to
18 chapter 48.43 RCW.
19 (3) Sections 401 through 404 of this act constitute a new chapter
20 in Title 49 RCW.

21 NEW SECTION. **Sec. 602.** Part headings and captions used in this
22 act are not any part of the law.

23 NEW SECTION. **Sec. 603.** The following acts or parts of acts are
24 each repealed, effective January 1, 2009:
25 (1) RCW 48.21.045 (Health plan benefits for small employers--
26 Coverage--Exemption from statutory requirements--Premium rates--
27 Requirements for providing coverage for small employers--Definitions)
28 and 2004 c 244 s 1, 1995 c 265 s 14, & 1990 c 187 s 2;
29 (2) RCW 48.21.047 (Requirements for plans offered to small
30 employers--Definitions) and 2005 c 223 s 11 & 1995 c 265 s 22;
31 (3) RCW 48.44.023 (Health plan benefits for small employers--
32 Coverage--Exemption from statutory requirements--Premium rates--
33 Requirements for providing coverage for small employers) and 2004 c 244
34 s 7, 1995 c 265 s 16, & 1990 c 187 s 3;

1 (4) RCW 48.44.024 (Requirements for plans offered to small
2 employers--Definitions) and 2003 c 248 s 15 & 1995 c 265 s 23;
3 (5) RCW 48.46.066 (Health plan benefits for small employers--
4 Coverage--Exemption from statutory requirements--Premium rates--
5 Requirements for providing coverage for small employers) and 2004 c 244
6 s 9, 1995 c 265 s 18, & 1990 c 187 s 4;
7 (6) RCW 48.46.068 (Requirements for plans offered to small
8 employers--Definitions) and 2003 c 248 s 16 & 1995 c 265 s 24;
9 (7) RCW 70.47A.010 (Finding--Intent) and 2006 c 255 s 1;
10 (8) RCW 70.47A.020 (Definitions) and 2006 c 255 s 2;
11 (9) RCW 70.47A.030 (Program established--Administrator duties) and
12 2006 c 255 s 3;
13 (10) RCW 70.47A.040 (Premium subsidies--Enrollment verification,
14 status changes--Administrator duties--Rules) and 2006 c 255 s 4;
15 (11) RCW 70.47A.050 (Enrollment to remain within appropriation) and
16 2006 c 255 s 5;
17 (12) RCW 70.47A.060 (Rules) and 2006 c 255 s 6;
18 (13) RCW 70.47A.070 (Reports) and 2006 c 255 s 7;
19 (14) RCW 70.47A.080 (Small employer health insurance partnership
20 program account) and 2006 c 255 s 8;
21 (15) RCW 70.47A.090 (State children's health insurance program--
22 Federal waiver request) and 2006 c 255 s 9; and
23 (16) RCW 70.47A.900 (Captions not law--2006 c 255) and 2006 c 255
24 s 11.

25 NEW SECTION. **Sec. 604.** Sections 304 through 306 of this act take
26 effect January 1, 2009.

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