

2 2SSB 6067 - S AMD - 100
3 By Senator Deccio

4 PULLED 2/29/00

5 Strike everything after the enacting clause and insert the
6 following:

7 "Sec. 1. RCW 48.04.010 and 1990 1st ex.s. c 3 s 1 are each amended
8 to read as follows:

9 (1) The commissioner may hold a hearing for any purpose within the
10 scope of this code as he or she may deem necessary. The commissioner
11 shall hold a hearing:

12 (a) If required by any provision of this code; or

13 (b) Upon written demand for a hearing made by any person aggrieved
14 by any act, threatened act, or failure of the commissioner to act, if
15 such failure is deemed an act under any provision of this code, or by
16 any report, promulgation, or order of the commissioner other than an
17 order on a hearing of which such person was given actual notice or at
18 which such person appeared as a party, or order pursuant to the order
19 on such hearing.

20 (2) Any such demand for a hearing shall specify in what respects
21 such person is so aggrieved and the grounds to be relied upon as basis
22 for the relief to be demanded at the hearing.

23 (3) Unless a person aggrieved by a written order of the
24 commissioner demands a hearing thereon within ninety days after
25 receiving notice of such order, or in the case of a licensee under
26 Title 48 RCW within ninety days after the commissioner has mailed the
27 order to the licensee at the most recent address shown in the
28 commissioner's licensing records for the licensee, the right to such
29 hearing shall conclusively be deemed to have been waived.

30 (4) If a hearing is demanded by a licensee whose license has been
31 temporarily suspended pursuant to RCW 48.17.540, the commissioner shall
32 hold such hearing demanded within thirty days after receipt of the
33 demand or within thirty days of the effective date of a temporary
34 license suspension issued after such demand, unless postponed by mutual
35 consent.

1 (5) A licensee under this title may request that a hearing
2 authorized under this section be presided over by an administrative law
3 judge assigned under chapter 34.12 RCW. Any such request shall not be
4 denied.

5 (6) Any hearing held relating to section 3, 27, or 30 of this act
6 shall be presided over by an administrative law judge assigned under
7 chapter 34.12 RCW.

8 **Sec. 2.** RCW 48.18.110 and 1985 c 264 s 9 are each amended to read
9 as follows:

10 (1) The commissioner shall disapprove any such form of policy,
11 application, rider, or endorsement, or withdraw any previous approval
12 thereof, only:

13 (a) If it is in any respect in violation of or does not comply with
14 this code or any applicable order or regulation of the commissioner
15 issued pursuant to the code; or

16 (b) If it does not comply with any controlling filing theretofore
17 made and approved; or

18 (c) If it contains or incorporates by reference any inconsistent,
19 ambiguous or misleading clauses, or exceptions and conditions which
20 unreasonably or deceptively affect the risk purported to be assumed in
21 the general coverage of the contract; or

22 (d) If it has any title, heading, or other indication of its
23 provisions which is misleading; or

24 (e) If purchase of insurance thereunder is being solicited by
25 deceptive advertising.

26 (2) In addition to the grounds for disapproval of any such form as
27 provided in subsection (1) of this section, the commissioner may
28 disapprove any form of disability insurance policy, except an
29 individual health benefit plan, if the benefits provided therein are
30 unreasonable in relation to the premium charged.

31 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.20 RCW
32 to read as follows:

33 (1) The definitions in this subsection apply throughout this
34 section unless the context clearly requires otherwise.

35 (a) "Claims" means the cost to the insurer of health care services,
36 as defined in RCW 48.43.005, provided to an enrollee or paid to or on
37 behalf of the enrollee in accordance with the terms of a health benefit

1 plan, as defined in RCW 48.43.005. This includes capitation payments
2 or other similar payments made to providers for the purpose of paying
3 for health care services for an enrollee.

4 (b) "Claims reserves" means: (i) The liability for claims which
5 have been reported but not paid; (ii) the liability for claims which
6 have not been reported but which may reasonably be expected; (iii)
7 active life reserves; and (iv) additional claims reserves whether for
8 a specific liability purpose or not.

9 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,
10 plus any rate credits or recoupments less any refunds, for the
11 applicable period, whether received before, during, or after the
12 applicable period.

13 (d) "Incurred claims expense" means claims paid during the
14 applicable period plus any increase, or less any decrease, in the
15 claims reserves.

16 (e) "Loss ratio" means incurred claims expense as a percentage of
17 earned premiums.

18 (f) "Premiums earned" means premiums, as defined in RCW 48.43.005
19 plus any rate credits or recoupments less any refunds for the
20 applicable period whether received before, during, or after the
21 applicable period.

22 (g) "Reserves" means: (i) Active life reserves; and (ii)
23 additional reserves whether for a specific liability purpose or not.

24 (2) An insurer shall file, for informational purposes only, a
25 notice of its schedule of rates for its individual health benefit plans
26 with the commissioner prior to use.

27 (3) An insurer shall file with the notice required under subsection
28 (2) of this section supporting documentation of its method of
29 determining the rates charged. The commissioner may request only the
30 following supporting documentation:

31 (a) A description of the insurer's rate-making methodology;

32 (b) An actuarially determined estimate of incurred claims which
33 includes the experience data, assumptions, and justifications of the
34 insurer's projection;

35 (c) The percentage of premium attributable in aggregate for
36 nonclaims expenses used to determine the adjusted community rates
37 charged; and

38 (d) A certification by a member of the American academy of
39 actuaries, or other person acceptable to the commissioner, that the

1 adjusted community rate charged can be reasonably expected to result in
2 a loss ratio that meets or exceeds the loss ratio standard established
3 in subsection (7) of this section.

4 (4) The commissioner may not disapprove or otherwise impede the
5 implementation of the filed rates.

6 (5) By the last day of May each year any insurer providing
7 individual health benefit plans in this state shall file for review by
8 the commissioner supporting documentation of its actual loss ratio for
9 its individual health benefit plans offered in the state in aggregate
10 for the preceding calendar year. The filing shall include a
11 certification by a member of the American academy of actuaries, or
12 other person acceptable to the commissioner, that the actual loss ratio
13 has been calculated in accordance with accepted actuarial principles.

14 (a) At the expiration of a thirty-day period commencing with the
15 date the filing is delivered to the commissioner, the filing shall be
16 deemed approved unless prior thereto the commissioner contests the
17 calculation of the actual loss ratio.

18 (b) If the commissioner contests the calculation of the actual loss
19 ratio, the commissioner shall state in writing the grounds for
20 contesting the calculation to the insurer.

21 (c) Any dispute regarding the calculation of the actual loss ratio
22 shall, upon written demand of either the commissioner or the insurer,
23 be submitted to hearing under chapters 48.04 and 34.05 RCW.

24 (6) If the actual loss ratio for the preceding calendar year is
25 less than the loss ratio established in subsection (7) of this section,
26 refunds are due and the following shall apply:

27 (a) The insurer shall calculate a percentage of premium to be
28 remitted to the Washington state health insurance pool by subtracting
29 the actual loss ratio for the preceding year from the loss ratio
30 established in subsection (7) of this section.

31 (b) The remittance to the Washington state health insurance pool is
32 the percentage calculated in (a) of the subsection, multiplied by the
33 premium earned from each enrollee in the previous calendar year.
34 Interest shall be added to the remittance due at a five percent annual
35 rate calculated from the end of the calendar year for which remittances
36 are due to the date the remittances are made.

37 (c) All remittances shall be aggregated and such amounts shall be
38 remitted to the Washington state high risk pool to be used as directed
39 by the pool board of directors.

1 (d) Any remittance required to be issued under this section shall
2 be issued within thirty days after the actual loss ratio is deemed
3 approved under subsection (5)(a) of this section or the determination
4 by an administrative law judge under subsection (5)(c) of this section.

5 (7) The loss ratio applicable to this section shall be seventy-four
6 percent minus the premium tax rate applicable to the insurer's
7 individual health benefit plans under RCW 48.14.0201.

8 **Sec. 4.** RCW 48.20.028 and 1997 c 231 s 207 are each amended to
9 read as follows:

10 ~~(1)((a) An insurer offering any health benefit plan to any~~
11 ~~individual shall offer and actively market to all individuals a health~~
12 ~~benefit plan providing benefits identical to the schedule of covered~~
13 ~~health benefits that are required to be delivered to an individual~~
14 ~~enrolled in the basic health plan subject to RCW 48.43.025 and~~
15 ~~48.43.035. Nothing in this subsection shall preclude an insurer from~~
16 ~~offering, or an individual from purchasing, other health benefit plans~~
17 ~~that may have more or less comprehensive benefits than the basic health~~
18 ~~plan, provided such plans are in accordance with this chapter. An~~
19 ~~insurer offering a health benefit plan that does not include benefits~~
20 ~~provided in the basic health plan shall clearly disclose these~~
21 ~~differences to the individual in a brochure approved by the~~
22 ~~commissioner.~~

23 ~~(b) A health benefit plan shall provide coverage for hospital~~
24 ~~expenses and services rendered by a physician licensed under chapter~~
25 ~~18.57 or 18.71 RCW but is not subject to the requirements of RCW~~
26 ~~48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411,~~
27 ~~48.20.412, 48.20.416, and 48.20.420 if the health benefit plan is the~~
28 ~~mandatory offering under (a) of this subsection that provides benefits~~
29 ~~identical to the basic health plan, to the extent these requirements~~
30 ~~differ from the basic health plan.~~

31 ~~(2))~~ Premiums for health benefit plans for individuals shall be
32 calculated using the adjusted community rating method that spreads
33 financial risk across the carrier's entire individual product
34 population. All such rates shall conform to the following:

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

37 (i) Geographic area;

38 (ii) Family size;

1 (iii) Age;

2 (iv) Tenure discounts; and

3 (v) Wellness activities.

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

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

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

17 (e) A discount for wellness activities shall be permitted to
18 reflect actuarially justified differences in utilization or cost
19 attributed to such programs not to exceed twenty percent.

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

23 (i) Changes to the family composition;

24 (ii) Changes to the health benefit plan requested by the
25 individual; or

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

28 (g) For the purposes of this section, a health benefit plan that
29 contains a restricted network provision shall not be considered similar
30 coverage to a health benefit plan that does not contain such a
31 provision, provided that the restrictions of benefits to network
32 providers result in substantial differences in claims costs. This
33 subsection does not restrict or enhance the portability of benefits as
34 provided in RCW 48.43.015.

35 (h) A tenure discount for continuous enrollment in the health plan
36 of two years or more may be offered, not to exceed ten percent.

37 ~~((+3+))~~ (2) Adjusted community rates established under this section
38 shall pool the medical experience of all individuals purchasing
39 coverage, and shall not be required to be pooled with the medical

1 experience of health benefit plans offered to small employers under RCW
2 48.21.045.

3 ~~((4))~~ (3) As used in this section, "health benefit plan,"
4 ~~("basic health plan,")~~ "adjusted community rate," and "wellness
5 activities" mean the same as defined in RCW 48.43.005.

6 **Sec. 5.** RCW 48.41.020 and 1987 c 431 s 2 are each amended to read
7 as follows:

8 It is the purpose and intent of the legislature to provide access
9 to health insurance coverage to all residents of Washington who are
10 denied ~~((adequate))~~ health insurance ~~((for any reason. It is the
11 intent of the legislature that adequate levels of health insurance
12 coverage be made available to residents of Washington who are otherwise
13 considered uninsurable or who are underinsured))~~. It is the intent of
14 the Washington state health insurance coverage access act to provide a
15 mechanism to ~~((insure))~~ ensure the availability of comprehensive health
16 insurance to persons unable to obtain such insurance coverage on either
17 an individual or group basis directly under any health plan.

18 **Sec. 6.** RCW 48.41.030 and 1997 c 337 s 6 are each amended to read
19 as follows:

20 ~~((As used in this chapter, the following terms have the meaning
21 indicated,))~~ The definitions in this section apply throughout this
22 chapter unless the context clearly requires otherwise((÷)).

23 (1) "Accounting year" means a twelve-month period determined by the
24 board for purposes of record-keeping and accounting. The first
25 accounting year may be more or less than twelve months and, from time
26 to time in subsequent years, the board may order an accounting year of
27 other than twelve months as may be required for orderly management and
28 accounting of the pool.

29 (2) "Administrator" means the entity chosen by the board to
30 administer the pool under RCW 48.41.080.

31 (3) "Board" means the board of directors of the pool.

32 (4) "Commissioner" means the insurance commissioner.

33 (5) "Covered person" means any individual resident of this state
34 who is eligible to receive benefits from any member, or other health
35 plan.

36 (6) "Health care facility" has the same meaning as in RCW
37 70.38.025.

1 (7) "Health care provider" means any physician, facility, or health
2 care professional, who is licensed in Washington state and entitled to
3 reimbursement for health care services.

4 (8) "Health care services" means services for the purpose of
5 preventing, alleviating, curing, or healing human illness or injury.

6 (9) "Health carrier" or "carrier" has the same meaning as in RCW
7 48.43.005.

8 (10) "Health coverage" means any group or individual disability
9 insurance policy, health care service contract, and health maintenance
10 agreement, except those contracts entered into for the provision of
11 health care services pursuant to Title XVIII of the Social Security
12 Act, 42 U.S.C. Sec. 1395 et seq. The term does not include short-term
13 care, long-term care, dental, vision, accident, fixed indemnity,
14 disability income contracts, civilian health and medical program for
15 the uniform services (CHAMPUS), 10 U.S.C. 55, limited benefit or credit
16 insurance, coverage issued as a supplement to liability insurance,
17 insurance arising out of the worker's compensation or similar law,
18 automobile medical payment insurance, or insurance under which benefits
19 are payable with or without regard to fault and which is statutorily
20 required to be contained in any liability insurance policy or
21 equivalent self-insurance.

22 ~~((+10+))~~ (11) "Health plan" means any arrangement by which persons,
23 including dependents or spouses, covered or making application to be
24 covered under this pool, have access to hospital and medical benefits
25 or reimbursement including any group or individual disability insurance
26 policy; health care service contract; health maintenance agreement;
27 uninsured arrangements of group or group-type contracts including
28 employer self-insured, cost-plus, or other benefit methodologies not
29 involving insurance or not governed by Title 48 RCW; coverage under
30 group-type contracts which are not available to the general public and
31 can be obtained only because of connection with a particular
32 organization or group; and coverage by medicare or other governmental
33 benefits. This term includes coverage through "health coverage" as
34 defined under this section, and specifically excludes those types of
35 programs excluded under the definition of "health coverage" in
36 subsection ~~((+9+))~~ (10) of this section.

37 ~~((+11+))~~ (12) "Medical assistance" means coverage under Title XIX
38 of the federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and
39 chapter 74.09 RCW.

1 (~~(12)~~) (13) "Medicare" means coverage under Title XVIII of the
2 Social Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

3 (~~(13)~~) (14) "Member" means any commercial insurer which provides
4 disability insurance, any health care service contractor, and any
5 health maintenance organization licensed under Title 48 RCW. "Member"
6 shall also mean, as soon as authorized by federal law, employers and
7 other entities, including a self-funding entity and employee welfare
8 benefit plans that provide health plan benefits in this state on or
9 after May 18, 1987. "Member" does not include any insurer, health care
10 service contractor, or health maintenance organization whose products
11 are exclusively dental products or those products excluded from the
12 definition of "health coverage" set forth in subsection (~~(9)~~) (10) of
13 this section.

14 (~~(14)~~) (15) "Network provider" means a health care provider who
15 has contracted in writing with the pool administrator or a health
16 carrier contracting with the pool administrator to offer pool coverage
17 to accept payment from and to look solely to the pool or health carrier
18 according to the terms of the pool health plans.

19 (~~(15)~~) (16) "Plan of operation" means the pool, including
20 articles, by-laws, and operating rules, adopted by the board pursuant
21 to RCW 48.41.050.

22 (~~(16)~~) (17) "Point of service plan" means a benefit plan offered
23 by the pool under which a covered person may elect to receive covered
24 services from network providers, or nonnetwork providers at a reduced
25 rate of benefits.

26 (~~(17)~~) (18) "Pool" means the Washington state health insurance
27 pool as created in RCW 48.41.040.

28 (~~(18)~~ "Substantially equivalent health plan" means a "health plan"
29 as defined in subsection (10) of this section which, in the judgment of
30 the board or the administrator, offers persons including dependents or
31 spouses covered or making application to be covered by this pool an
32 overall level of benefits deemed approximately equivalent to the
33 minimum benefits available under this pool.)

34 **Sec. 7.** RCW 48.41.060 and 1997 c 337 s 5 are each amended to read
35 as follows:

36 (1) The board shall have the general powers and authority granted
37 under the laws of this state to insurance companies, health care
38 service contractors, and health maintenance organizations, licensed or

1 registered to offer or provide the kinds of health coverage defined
2 under this title. In addition thereto, the board ((may:

3 ~~(1) Enter into contracts as are necessary or proper to carry out~~
4 ~~the provisions and purposes of this chapter including the authority,~~
5 ~~with the approval of the commissioner, to enter into contracts with~~
6 ~~similar pools of other states for the joint performance of common~~
7 ~~administrative functions, or with persons or other organizations for~~
8 ~~the performance of administrative functions;~~

9 ~~(2) Sue or be sued, including taking any legal action as necessary~~
10 ~~to avoid the payment of improper claims against the pool or the~~
11 ~~coverage provided by or through the pool;~~

12 ~~(3)) shall:~~

13 (a) Designate or establish the standard health questionnaire to be
14 used under RCW 48.41.100 and section 20 of this act, including the form
15 and content of the standard health questionnaire and the method of its
16 application. The questionnaire must provide for an objective
17 evaluation of an individual's health status by assigning a discreet
18 measure, such as a system of point scoring to each individual. The
19 questionnaire must not contain any questions related to pregnancy, and
20 pregnancy shall not be a basis for coverage by the pool. The
21 questionnaire shall be designed such that it is reasonably expected to
22 identify the eight percent of persons who are the most costly to treat
23 who are under individual coverage in health benefit plans, as defined
24 in RCW 48.43.005, in Washington state or are covered by the pool, if
25 applied to all such persons;

26 (b) Obtain from a member of the American academy of actuaries, who
27 is independent of the board, a certification that the standard health
28 questionnaire meets the requirements of (a) of this subsection;

29 (c) Approve the standard health questionnaire and any modifications
30 needed to comply with this chapter. The standard health questionnaire
31 shall be submitted to an actuary for certification, modified as
32 necessary, and approved at least every eighteen months. The
33 designation and approval of the standard health questionnaire by the
34 board shall not be subject to review and approval by the commissioner.
35 The standard health questionnaire or any modification thereto shall not
36 be used until ninety days after public notice of the approval of the
37 questionnaire or any modification thereto, except that the initial
38 standard health questionnaire approved for use by the board after the

1 effective date of this section may be used immediately following public
2 notice of such approval;

3 (d) Establish appropriate rates, rate schedules, rate adjustments,
4 expense allowances, agent referral fees, claim reserve formulas and any
5 other actuarial functions appropriate to the operation of the pool.
6 Rates shall not be unreasonable in relation to the coverage provided,
7 the risk experience, and expenses of providing the coverage. Rates and
8 rate schedules may be adjusted for appropriate risk factors such as age
9 and area variation in claim costs and shall take into consideration
10 appropriate risk factors in accordance with established actuarial
11 underwriting practices consistent with Washington state small group
12 plan rating requirements under RCW 48.44.023 and 48.46.066;

13 ~~((+4))~~ (e) Assess members of the pool in accordance with the
14 provisions of this chapter, and make advance interim assessments as may
15 be reasonable and necessary for the organizational or interim operating
16 expenses. Any interim assessments will be credited as offsets against
17 any regular assessments due following the close of the year;

18 ~~((+5))~~ (f) Issue policies of health coverage in accordance with
19 the requirements of this chapter; and

20 ~~((+6))~~ (g) Provide certification to the commissioner when
21 assessments will exceed the threshold level established in section 34
22 of this act.

23 (2) In addition thereto, the board may:

24 (a) Enter into contracts as are necessary or proper to carry out
25 the provisions and purposes of this chapter including the authority,
26 with the approval of the commissioner, to enter into contracts with
27 similar pools of other states for the joint performance of common
28 administrative functions, or with persons or other organizations for
29 the performance of administrative functions;

30 (b) Sue or be sued, including taking any legal action as necessary
31 to avoid the payment of improper claims against the pool or the
32 coverage provided by or through the pool;

33 (c) Appoint appropriate legal, actuarial, and other committees as
34 necessary to provide technical assistance in the operation of the pool,
35 policy, and other contract design, and any other function within the
36 authority of the pool; and

37 ~~((+7))~~ (d) Conduct periodic audits to assure the general accuracy
38 of the financial data submitted to the pool, and the board shall cause

1 the pool to have an annual audit of its operations by an independent
2 certified public accountant.

3 (3) Notwithstanding chapter 34.05 RCW, nothing in this section
4 shall be considered a rule.

5 **Sec. 8.** RCW 48.41.080 and 1997 c 231 s 212 are each amended to
6 read as follows:

7 The board shall select an administrator from the membership of the
8 pool whether domiciled in this state or another state through a
9 competitive bidding process to administer the pool.

10 (1) The board shall evaluate bids based upon criteria established
11 by the board, which shall include:

12 (a) The administrator's proven ability to handle health coverage;

13 (b) The efficiency of the administrator's claim-paying procedures;

14 (c) An estimate of the total charges for administering the plan;
15 and

16 (d) The administrator's ability to administer the pool in a cost-
17 effective manner.

18 (2) The administrator shall serve for a period of three years
19 subject to removal for cause. At least six months prior to the
20 expiration of each three-year period of service by the administrator,
21 the board shall invite all interested parties, including the current
22 administrator, to submit bids to serve as the administrator for the
23 succeeding three-year period. Selection of the administrator for this
24 succeeding period shall be made at least three months prior to the end
25 of the current three-year period.

26 (3) The administrator shall perform such duties as may be assigned
27 by the board including:

28 (a) ~~((All))~~ Administering eligibility and administrative claim
29 payment functions relating to the pool;

30 (b) Establishing a premium billing procedure for collection of
31 premiums from covered persons. Billings shall be made on a periodic
32 basis as determined by the board, which shall not be more frequent than
33 a monthly billing;

34 (c) Performing all necessary functions to assure timely payment of
35 benefits to covered persons under the pool including:

36 (i) Making available information relating to the proper manner of
37 submitting a claim for benefits to the pool, and distributing forms
38 upon which submission shall be made;

1 (ii) Taking steps necessary to offer and administer managed care
2 benefit plans; and

3 (iii) Evaluating the eligibility of each claim for payment by the
4 pool;

5 (d) Submission of regular reports to the board regarding the
6 operation of the pool. The frequency, content, and form of the report
7 shall be as determined by the board;

8 (e) Following the close of each accounting year, determination of
9 net paid and earned premiums, the expense of administration, and the
10 paid and incurred losses for the year and reporting this information to
11 the board and the commissioner on a form as prescribed by the
12 commissioner.

13 (4) The administrator shall be paid as provided in the contract
14 between the board and the administrator for its expenses incurred in
15 the performance of its services.

16 **Sec. 9.** RCW 48.41.090 and 1989 c 121 s 6 are each amended to read
17 as follows:

18 (1) Following the close of each accounting year, the pool
19 administrator shall determine the net premium (premiums less
20 administrative expense allowances), the pool expenses of
21 administration, and incurred losses for the year, taking into account
22 investment income and other appropriate gains and losses.

23 (2)(a) Each member's proportion of participation in the pool shall
24 be determined annually by the board based on annual statements and
25 other reports deemed necessary by the board and filed by the member
26 with the commissioner; and shall be determined by multiplying the total
27 cost of pool operation by a fraction(~~($\frac{1}{7}$)~~). ~~The numerator of ((which))~~
28 the fraction equals that member's total: Number of resident insured
29 persons, including spouse and dependents under the member's health
30 plans in the state during the preceding calendar year(~~($\frac{1}{7}$ and)~~). The
31 denominator of ((which)) the fraction equals the total number of
32 resident insured persons including spouses and dependents insured under
33 all health plans in the state by pool members.

34 (b) Except as provided in section 34 of this act, any deficit
35 incurred by the pool shall be recouped by assessments among members
36 apportioned under this subsection pursuant to the formula set forth by
37 the board among members.

1 (3) The board may abate or defer, in whole or in part, the
2 assessment of a member if, in the opinion of the board, payment of the
3 assessment would endanger the ability of the member to fulfill its
4 contractual obligations. If an assessment against a member is abated
5 or deferred in whole or in part, the amount by which such assessment is
6 abated or deferred may be assessed against the other members in a
7 manner consistent with the basis for assessments set forth in
8 subsection (2) of this section. The member receiving such abatement or
9 deferment shall remain liable to the pool for the deficiency.

10 (4) If assessments exceed actual losses and administrative expenses
11 of the pool, the excess shall be held at interest and used by the board
12 to offset future losses or to reduce pool premiums. As used in this
13 subsection, "future losses" includes reserves for incurred but not
14 reported claims.

15 **Sec. 10.** RCW 48.41.100 and 1995 c 34 s 5 are each amended to read
16 as follows:

17 (1) ~~((Any individual))~~ The following persons who ~~((is a))~~ are
18 residents of this state ((is)) are eligible for pool coverage ~~((upon~~
19 ~~providing evidence of rejection for medical reasons, a requirement of~~
20 ~~restrictive riders, an up-rated premium, or a preexisting conditions~~
21 ~~limitation on health insurance, the effect of which is to substantially~~
22 ~~reduce coverage from that received by a person considered a standard~~
23 ~~risk, by at least one member within six months of the date of~~
24 ~~application. Evidence of rejection may be waived in accordance with~~
25 ~~rules adopted by the board))~~);

26 (a) Any person who provides evidence of a carrier's decision not to
27 accept him or her for enrollment in an individual health benefit plan
28 as defined in RCW 48.43.005 based upon the results of the standard
29 health questionnaire designated by the board and administered by health
30 carriers under section 20 of this act;

31 (b) Any person who resides in a county of the state where no member
32 offers to the public any individual health benefit plan as defined in
33 RCW 48.43.005 at the time of application to the pool and makes direct
34 application to the pool.

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

37 (a) Any person having terminated coverage in the pool unless (i)
38 twelve months have lapsed since termination, or (ii) that person can

1 show continuous other coverage which has been involuntarily terminated
2 for any reason other than nonpayment of premiums;

3 (b) Any person on whose behalf the pool has paid out five hundred
4 thousand dollars in benefits;

5 (c) Inmates of public institutions and persons whose benefits are
6 duplicated under public programs;

7 (d) Any person who resides in a county of the state where any
8 member offers to the public an individual health benefit plan as
9 defined in RCW 48.43.005 at the time of application to the pool and
10 does not qualify for pool coverage based upon the results of the
11 standard health questionnaire.

12 ~~((3) Any person whose health insurance coverage is involuntarily~~
13 ~~terminated for any reason other than nonpayment of premium may apply~~
14 ~~for coverage under the plan.))~~

15 **Sec. 11.** RCW 48.41.110 and 1997 c 231 s 213 are each amended to
16 read as follows:

17 (1) The pool ~~((is authorized to))~~ shall offer one or more
18 ~~((managed))~~ care management plans of coverage. Such plans may, but are
19 not required to, include point of service features that permit
20 participants to receive in-network benefits or out-of-network benefits
21 subject to differential cost shares. Covered persons enrolled in the
22 pool on January 1, ~~((1997))~~ 2001, may continue coverage under the pool
23 plan in which they are enrolled on that date. However, the pool may
24 incorporate managed care features into such existing plans.

25 (2) The administrator shall prepare a brochure outlining the
26 benefits and exclusions of the pool policy in plain language. After
27 approval by the board ~~((of directors))~~, such brochure shall be made
28 reasonably available to participants or potential participants.

29 (3) The health insurance policy issued by the pool shall pay only
30 ~~((usual, customary, and))~~ reasonable ~~((charges))~~ amounts for medically
31 necessary eligible health care services rendered or furnished for the
32 diagnosis or treatment of illnesses, injuries, and conditions which are
33 not otherwise limited or excluded. Eligible expenses are the ~~((usual,~~
34 ~~customary, and))~~ reasonable ~~((charges))~~ amounts for the health care
35 services and items for which benefits are extended under the pool
36 policy. Such benefits shall at minimum include, but not be limited to,
37 the following services or related items:

- 1 (a) Hospital services, including charges for the most common
2 semiprivate room, for the most common private room if semiprivate rooms
3 do not exist in the health care facility, or for the private room if
4 medically necessary, but limited to a total of one hundred eighty
5 inpatient days in a calendar year, and limited to thirty days inpatient
6 care for mental and nervous conditions, or alcohol, drug, or chemical
7 dependency or abuse per calendar year;
- 8 (b) Professional services including surgery for the treatment of
9 injuries, illnesses, or conditions, other than dental, which are
10 rendered by a health care provider, or at the direction of a health
11 care provider, by a staff of registered or licensed practical nurses,
12 or other health care providers;
- 13 (c) The first twenty outpatient professional visits for the
14 diagnosis or treatment of one or more mental or nervous conditions or
15 alcohol, drug, or chemical dependency or abuse rendered during a
16 calendar year by one or more physicians, psychologists, or community
17 mental health professionals, or, at the direction of a physician, by
18 other qualified licensed health care practitioners, in the case of
19 mental or nervous conditions, and rendered by a state certified
20 chemical dependency program approved under chapter 70.96A RCW, in the
21 case of alcohol, drug, or chemical dependency or abuse;
- 22 (d) Drugs and contraceptive devices requiring a prescription;
- 23 (e) Services of a skilled nursing facility, excluding custodial and
24 convalescent care, for not more than one hundred days in a calendar
25 year as prescribed by a physician;
- 26 (f) Services of a home health agency;
- 27 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
28 therapy;
- 29 (h) Oxygen;
- 30 (i) Anesthesia services;
- 31 (j) Prostheses, other than dental;
- 32 (k) Durable medical equipment which has no personal use in the
33 absence of the condition for which prescribed;
- 34 (l) Diagnostic x-rays and laboratory tests;
- 35 (m) Oral surgery limited to the following: Fractures of facial
36 bones; excisions of mandibular joints, lesions of the mouth, lip, or
37 tongue, tumors, or cysts excluding treatment for temporomandibular
38 joints; incision of accessory sinuses, mouth salivary glands or ducts;
39 dislocations of the jaw; plastic reconstruction or repair of traumatic

1 injuries occurring while covered under the pool; and excision of
2 impacted wisdom teeth;

3 (n) Maternity care services (~~(, as provided in the managed care plan~~
4 ~~to be designed by the pool board of directors, and for which no~~
5 ~~preexisting condition waiting periods may apply))~~);

6 (o) Services of a physical therapist and services of a speech
7 therapist;

8 (p) Hospice services;

9 (q) Professional ambulance service to the nearest health care
10 facility qualified to treat the illness or injury; and

11 (r) Other medical equipment, services, or supplies required by
12 physician's orders and medically necessary and consistent with the
13 diagnosis, treatment, and condition.

14 (~~(+3)~~) (4) The board shall design and employ cost containment
15 measures and requirements such as, but not limited to, care
16 coordination, provider network limitations, preadmission certification,
17 and concurrent inpatient review which may make the pool more cost-
18 effective.

19 (~~(+4)~~) (5) The pool benefit policy may contain benefit
20 limitations, exceptions, and cost shares such as copayments,
21 coinsurance, and deductibles that are consistent with managed care
22 products, except that differential cost shares may be adopted by the
23 board for nonnetwork providers under point of service plans. The pool
24 benefit policy cost shares and limitations must be consistent with
25 those that are generally included in health plans approved by the
26 insurance commissioner; however, no limitation, exception, or reduction
27 may be used that would exclude coverage for any disease, illness, or
28 injury.

29 (~~(+5)~~) (6) The pool may not reject an individual for health plan
30 coverage based upon preexisting conditions of the individual or deny,
31 exclude, or otherwise limit coverage for an individual's preexisting
32 health conditions; except that it (~~(may)~~) shall impose a three-month
33 benefit waiting period for preexisting conditions for which medical
34 advice was given, (~~(or)~~) for which a health care provider recommended
35 or provided treatment, or for which a prudent layperson would have
36 sought advice or treatment, within (~~(three)~~) six months before the
37 effective date of coverage. The pool may not avoid the requirements of
38 this section through the creation of a new rate classification or the

1 modification of an existing rate classification. Credit against the
2 waiting period shall be provided as required by RCW 48.43.015.

3 **Sec. 12.** RCW 48.41.120 and 1989 c 121 s 8 are each amended to read
4 as follows:

5 (1) Subject to the limitation provided in subsection (3) of this
6 section, a pool policy offered in accordance with (~~this chapter~~) RCW
7 48.41.110(3) shall impose a deductible. Deductibles of five hundred
8 dollars and one thousand dollars on a per person per calendar year
9 basis shall initially be offered. The board may authorize deductibles
10 in other amounts. The deductible shall be applied to the first five
11 hundred dollars, one thousand dollars, or other authorized amount of
12 eligible expenses incurred by the covered person.

13 (2) Subject to the limitations provided in subsection (3) of this
14 section, a mandatory coinsurance requirement shall be imposed at the
15 rate of twenty percent of eligible expenses in excess of the mandatory
16 deductible.

17 (3) The maximum aggregate out of pocket payments for eligible
18 expenses by the insured in the form of deductibles and coinsurance
19 under a pool policy offered in accordance with RCW 48.41.110(3) shall
20 not exceed in a calendar year:

21 (a) One thousand five hundred dollars per individual, or three
22 thousand dollars per family, per calendar year for the five hundred
23 dollar deductible policy;

24 (b) Two thousand five hundred dollars per individual, or five
25 thousand dollars per family per calendar year for the one thousand
26 dollar deductible policy; or

27 (c) An amount authorized by the board for any other deductible
28 policy.

29 (4) Eligible expenses incurred by a covered person in the last
30 three months of a calendar year, and applied toward a deductible, shall
31 also be applied toward the deductible amount in the next calendar year.

32 **Sec. 13.** RCW 48.41.130 and 1997 c 231 s 215 are each amended to
33 read as follows:

34 All policy forms issued by the pool shall conform in substance to
35 prototype forms developed by the pool, and shall in all other respects
36 conform to the requirements of this chapter, and shall be filed with
37 and approved by the commissioner before they are issued. (~~The pool~~

1 shall not issue a pool policy to any individual who, on the effective
2 date of the coverage applied for, already has or would have coverage
3 substantially equivalent to a pool policy as an insured or covered
4 dependent, or who would be eligible for such coverage if he or she
5 elected to obtain it at a lesser premium rate. However, coverage
6 provided by the basic health plan, as established pursuant to chapter
7 70.47 RCW, shall not be deemed substantially equivalent for the
8 purposes of this section.))

9 NEW SECTION. **Sec. 14.** A new section is added to chapter 48.41 RCW
10 to read as follows:

11 The board shall design and offer a care management plan of coverage
12 with the following components:

13 (1) Services similar to those contained in RCW 48.41.110(3) shall
14 be covered.

15 (2) Alternative payment methodologies for network providers that
16 may include but are not limited to resource-based relative value fee
17 schedules, capitation payments, diagnostic related group fee schedules,
18 and other similar strategies including risk sharing arrangements.

19 (3) Enrollee cost-sharing that may include but not be limited to
20 point-of-service cost-sharing for covered services and deductibles in
21 amounts to be determined by the board. The board shall include an
22 annual maximum out-of-pocket payment protection in the plan.

23 (4) Other appropriate care management and cost containment measures
24 determined appropriate by the board, including but not limited to, care
25 coordination, provider network limitations, preadmission certification,
26 and utilization review.

27 **Sec. 15.** RCW 48.41.140 and 1987 c 431 s 14 are each amended to
28 read as follows:

29 (1) Coverage shall provide that health insurance benefits are
30 applicable to children of the person in whose name the policy is issued
31 including adopted and newly born natural children. Coverage shall also
32 include necessary care and treatment of medically diagnosed congenital
33 defects and birth abnormalities. If payment of a specific premium is
34 required to provide coverage for the child, the policy may require that
35 notification of the birth or adoption of a child and payment of the
36 required premium must be furnished to the pool within thirty-one days
37 after the date of birth or adoption in order to have the coverage

1 continued beyond the thirty-one day period. For purposes of this
2 subsection, a child is deemed to be adopted, and benefits are payable,
3 when the child is physically placed for purposes of adoption under the
4 laws of this state with the person in whose name the policy is issued;
5 and, when the person in whose name the policy is issued assumes
6 financial responsibility for the medical expenses of the child. For
7 purposes of this subsection, "newly born" means, and benefits are
8 payable, from the moment of birth.

9 (2) A pool policy shall provide that coverage of a dependent,
10 unmarried person shall terminate when the person becomes nineteen years
11 of age: PROVIDED, That coverage of such person shall not terminate at
12 age nineteen while he or she is and continues to be both (a) incapable
13 of self-sustaining employment by reason of developmental disability or
14 physical handicap and (b) chiefly dependent upon the person in whose
15 name the policy is issued for support and maintenance, provided proof
16 of such incapacity and dependency is furnished to the pool by the
17 policy holder within thirty-one days of the dependent's attainment of
18 age nineteen and subsequently as may be required by the pool but not
19 more frequently than annually after the two-year period following the
20 dependent's attainment of age nineteen.

21 ~~((3) A pool policy may contain provisions under which coverage is
22 excluded during a period of six months following the effective date of
23 coverage as to a given covered individual for preexisting conditions,
24 as long as medical advice or treatment was recommended or received
25 within a period of six months before the effective date of coverage.~~

26 ~~These preexisting condition exclusions shall be waived to the
27 extent to which similar exclusions have been satisfied under any prior
28 health insurance which was for any reason other than nonpayment of
29 premium involuntarily terminated, if the application for pool coverage
30 is made not later than thirty days following the involuntary
31 termination. In that case, with payment of appropriate premium,
32 coverage in the pool shall be effective from the date on which the
33 prior coverage was terminated.))~~

34 **Sec. 16.** RCW 48.41.200 and 1997 c 231 s 214 are each amended to
35 read as follows:

36 (1) The pool shall determine the standard risk rate by calculating
37 the average ~~((group))~~ individual standard rate ~~((for groups comprised
38 of up to fifty persons))~~ charged for coverage comparable to pool

1 coverage by the five largest members, measured in terms of individual
2 market enrollment, offering such coverages in the state ((comparable to
3 the pool coverage)). In the event five members do not offer comparable
4 coverage, the standard risk rate shall be established using reasonable
5 actuarial techniques and shall reflect anticipated experience and
6 expenses for such coverage in the individual market.

7 (2) Subject to subsection (3) of this section, maximum rates for
8 pool coverage shall be ((one hundred fifty percent for the indemnity
9 health plan and one hundred twenty-five percent for managed care plans
10 of the rates established as applicable for group standard risks in
11 groups comprised of up to fifty persons)) as follows:

12 (a) Maximum rates for a pool indemnity health plan shall be one
13 hundred fifty percent of the rate calculated under subsection (1) of
14 this section; and

15 (b) Maximum rates for a pool care management plan shall be one
16 hundred twenty-five percent of the rate calculated under subsection (1)
17 of this section.

18 (3)(a) Subject to (b) of this subsection the rate for any person
19 who has been enrolled in the pool for more than thirty-six months shall
20 be reduced by five percent from what it would otherwise be.

21 (b) In no event shall the rate for any person be less than the rate
22 calculated under subsection (1) of this section.

23 **Sec. 17.** RCW 48.43.005 and 1997 c 231 s 202 and 1997 c 55 s 1 are
24 each reenacted and amended to read as follows:

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

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

31 (2) "Basic health plan" means the plan described under chapter
32 70.47 RCW, as revised from time to time.

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

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

1 (5) "Catastrophic health plan" means:

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

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

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

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

25 (~~(6)~~) (7) "Concurrent review" means utilization review conducted
26 during a patient's hospital stay or course of treatment.

27 (~~(7)~~) (8) "Covered person" or "enrollee" means a person covered
28 by a health plan including an enrollee, subscriber, policyholder,
29 beneficiary of a group plan, or individual covered by any other health
30 plan.

31 (~~(8)~~) (9) "Dependent" means, at a minimum, the enrollee's legal
32 spouse and unmarried dependent children who qualify for coverage under
33 the enrollee's health benefit plan.

34 (~~(9)~~) (10) "Eligible employee" means an employee who works on a
35 full-time basis with a normal work week of thirty or more hours. The
36 term includes a self-employed individual, including a sole proprietor,
37 a partner of a partnership, and may include an independent contractor,
38 if the self-employed individual, sole proprietor, partner, or
39 independent contractor is included as an employee under a health

1 benefit plan of a small employer, but does not work less than thirty
2 hours per week and derives at least seventy-five percent of his or her
3 income from a trade or business through which he or she has attempted
4 to earn taxable income and for which he or she has filed the
5 appropriate internal revenue service form. Persons covered under a
6 health benefit plan pursuant to the consolidated omnibus budget
7 reconciliation act of 1986 shall not be considered eligible employees
8 for purposes of minimum participation requirements of chapter 265, Laws
9 of 1995.

10 ~~((10))~~ (11) "Emergency medical condition" means the emergent and
11 acute onset of a symptom or symptoms, including severe pain, that would
12 lead a prudent layperson acting reasonably to believe that a health
13 condition exists that requires immediate medical attention, if failure
14 to provide medical attention would result in serious impairment to
15 bodily functions or serious dysfunction of a bodily organ or part, or
16 would place the person's health in serious jeopardy.

17 ~~((11))~~ (12) "Emergency services" means otherwise covered health
18 care services medically necessary to evaluate and treat an emergency
19 medical condition, provided in a hospital emergency department.

20 ~~((12))~~ (13) "Enrollee point-of-service cost-sharing" means
21 amounts paid to health carriers directly providing services, health
22 care providers, or health care facilities by enrollees and may include
23 copayments, coinsurance, or deductibles.

24 ~~((13))~~ (14) "Grievance" means a written complaint submitted by or
25 on behalf of a covered person regarding: (a) Denial of payment for
26 medical services or nonprovision of medical services included in the
27 covered person's health benefit plan, or (b) service delivery issues
28 other than denial of payment for medical services or nonprovision of
29 medical services, including dissatisfaction with medical care, waiting
30 time for medical services, provider or staff attitude or demeanor, or
31 dissatisfaction with service provided by the health carrier.

32 ~~((14))~~ (15) "Health care facility" or "facility" means hospices
33 licensed under chapter 70.127 RCW, hospitals licensed under chapter
34 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,
35 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
36 licensed under chapter 18.51 RCW, community mental health centers
37 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
38 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
39 treatment, or surgical facilities licensed under chapter 70.41 RCW,

1 drug and alcohol treatment facilities licensed under chapter 70.96A
2 RCW, and home health agencies licensed under chapter 70.127 RCW, and
3 includes such facilities if owned and operated by a political
4 subdivision or instrumentality of the state and such other facilities
5 as required by federal law and implementing regulations.

6 ~~((15))~~ (16) "Health care provider" or "provider" means:

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

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

12 ~~((16))~~ (17) "Health care service" means that service offered or
13 provided by health care facilities and health care providers relating
14 to the prevention, cure, or treatment of illness, injury, or disease.

15 ~~((17))~~ (18) "Health carrier" or "carrier" means a disability
16 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
17 service contractor as defined in RCW 48.44.010, or a health maintenance
18 organization as defined in RCW 48.46.020.

19 ~~((18))~~ (19) "Health plan" or "health benefit plan" means any
20 policy, contract, or agreement offered by a health carrier to provide,
21 arrange, reimburse, or pay for health care services except the
22 following:

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

24 (b) Medicare supplemental health insurance governed by chapter
25 48.66 RCW;

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

28 (d) Disability income;

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

32 (f) Workers' compensation coverage;

33 (g) Accident only coverage;

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

36 (i) Employer-sponsored self-funded health plans;

37 (j) Dental only and vision only coverage; and

38 (k) Plans deemed by the insurance commissioner to have a short-term
39 limited purpose or duration, or to be a student-only plan that is

1 guaranteed renewable while the covered person is enrolled as a regular
2 full-time undergraduate or graduate student at an accredited higher
3 education institution, after a written request for such classification
4 by the carrier and subsequent written approval by the insurance
5 commissioner.

6 (~~((19))~~) (20) "Material modification" means a change in the
7 actuarial value of the health plan as modified of more than five
8 percent but less than fifteen percent.

9 (~~((20)~~ "Open enrollment" means the annual sixty-two day period
10 during the months of July and August during which every health carrier
11 offering individual health plan coverage must accept onto individual
12 coverage any state resident within the carrier's service area
13 regardless of health condition who submits an application in accordance
14 with ~~RCW 48.43.035(1)-)~~)

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

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

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

30 (24) "Small employer" means any person, firm, corporation,
31 partnership, association, political subdivision except school
32 districts, or self-employed individual that is actively engaged in
33 business that, on at least fifty percent of its working days during the
34 preceding calendar quarter, employed no more than fifty eligible
35 employees, with a normal work week of thirty or more hours, the
36 majority of whom were employed within this state, and is not formed
37 primarily for purposes of buying health insurance and in which a bona
38 fide employer-employee relationship exists. In determining the number
39 of eligible employees, companies that are affiliated companies, or that

1 are eligible to file a combined tax return for purposes of taxation by
2 this state, shall be considered an employer. Subsequent to the
3 issuance of a health plan to a small employer and for the purpose of
4 determining eligibility, the size of a small employer shall be
5 determined annually. Except as otherwise specifically provided, a
6 small employer shall continue to be considered a small employer until
7 the plan anniversary following the date the small employer no longer
8 meets the requirements of this definition. The term "small employer"
9 includes a self-employed individual or sole proprietor. The term
10 "small employer" also includes a self-employed individual or sole
11 proprietor who derives at least seventy-five percent of his or her
12 income from a trade or business through which the individual or sole
13 proprietor has attempted to earn taxable income and for which he or she
14 has filed the appropriate internal revenue service form 1040, schedule
15 C or F, for the previous taxable year.

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

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

28 **Sec. 18.** RCW 48.43.015 and 1995 c 265 s 5 are each amended to read
29 as follows:

30 (1) For group contracts as defined in chapter 48.44 RCW every
31 health carrier shall waive any preexisting condition exclusion or
32 limitation for persons or groups who had similar health coverage under
33 a different health plan at any time during the three-month period
34 immediately preceding the date of application for the new health plan
35 if such person was continuously covered under the immediately preceding
36 health plan. If the person was continuously covered for at least
37 (~~three~~) nine months under the immediately preceding health plan, the
38 carrier may not impose a waiting period for coverage of preexisting

1 conditions. If the person was continuously covered for less than
2 (~~three~~) nine months under the immediately preceding health plan, the
3 carrier must credit any waiting period under the immediately preceding
4 health plan toward the new health plan. For the purposes of this
5 subsection, a preceding health plan includes an employer provided self-
6 funded health plan.

7 (2) Subject to the provisions of subsections (1) and (3) of this
8 section, nothing contained in this section requires a health carrier to
9 amend a health plan to provide new benefits in its existing health
10 plans. In addition, nothing in this section requires a carrier to
11 waive benefit limitations not related to an individual or group's
12 preexisting conditions or health history.

13 (3) A health carrier shall credit any preexisting condition waiting
14 period in its individual plans for a person who was enrolled in a group
15 health benefit plan, or an individual health benefit plan other than a
16 catastrophic plan, at any time during the sixty-three day period
17 immediately preceding the date of application for the new health plan.
18 The carrier must credit the period of coverage the person was
19 continuously covered under the immediately preceding health plan toward
20 the waiting period of the new health plan. For the purposes of this
21 subsection, a preceding health plan includes an employer provided self-
22 funded health plan.

23 NEW SECTION. Sec. 19. A new section is added to chapter 48.43 RCW
24 to read as follows:

25 (1) No carrier may reject an individual for individual health plan
26 coverage based upon preexisting conditions of the individual except as
27 provided in section 20 of this act.

28 (2) No carrier may deny, exclude, or otherwise limit coverage for
29 an individual's preexisting health conditions except as provided in
30 this section.

31 (3) For individual coverage originally issued on or after the
32 effective date of this section preexisting condition waiting periods
33 imposed upon a person enrolling in individual coverage shall be no more
34 restrictive than nine months for a preexisting condition for which
35 medical advice was given, for which a health care provider recommended
36 or provided treatment, or for which a prudent layperson would have
37 sought advice or treatment, within six months prior to the effective
38 date of coverage.

1 (4) Individual coverage preexisting condition exclusion waiting
2 periods shall not apply to prenatal care services.

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

11 NEW SECTION. **Sec. 20.** A new section is added to chapter 48.43 RCW
12 to read as follows:

13 (1) Except as provided in (a) and (b) of this subsection, a health
14 carrier may require any person applying for an individual health plan
15 to complete the standard health questionnaire designated under chapter
16 48.41 RCW.

17 (a) If a person is seeking individual coverage due to his or her
18 change of residence from one geographic area in Washington state to
19 another geographic area in Washington state where his or her current
20 health coverage is not offered, completion of the standard health
21 questionnaire shall not be a condition of coverage if application for
22 coverage is made within ninety days of relocation.

23 (b) If a person is seeking individual coverage:

24 (i) Because a health care provider with whom he or she has an
25 established care relationship and from whom he or she has received
26 treatment within the past twelve months is no longer part of the
27 carrier's provider network under his or her existing Washington
28 individual coverage; and

29 (ii) His or her health care provider is part of another carrier's
30 provider network; and

31 (iii) Application for coverage under that carrier's provider
32 network individual coverage is made within ninety days of his or her
33 provider leaving the previous carrier's provider network; then
34 completion of the standard health questionnaire shall not be a
35 condition of coverage.

36 (2)(a) If, based upon the results of the standard health
37 questionnaire, the person qualifies for coverage under the Washington

1 state health insurance pool, the carrier may decide not to accept the
2 person's application for enrollment in its individual health plan.

3 (b) Within fifteen business days of receipt of a completed
4 application, the carrier shall provide written notice of the decision
5 not to accept the person's application for enrollment to both the
6 applicant and the administrator of the Washington state health
7 insurance pool. The notice to the applicant shall state that the
8 person is eligible for health insurance provided by the Washington
9 state health insurance pool, and shall include information about the
10 Washington state health insurance pool and an application for such
11 coverage.

12 (3) If, based upon the results of the standard health
13 questionnaire, the person does not qualify for coverage under the
14 Washington state health insurance pool, the carrier shall accept the
15 person for enrollment if he or she resides within the carrier's service
16 area and provide or assure the provision of all covered services
17 regardless of age, sex, family structure, ethnicity, race, health
18 condition, geographic location, employment status, socioeconomic
19 status, other condition or situation, or the provisions of RCW
20 49.60.174(2). The commissioner may grant a temporary exemption from
21 this subsection if, upon application by a health carrier, the
22 commissioner finds that the clinical, financial, or administrative
23 capacity to serve existing enrollees will be impaired if a health
24 carrier is required to continue enrollment of additional eligible
25 individuals.

26 (4) Except as otherwise required by statute or rule, a carrier and
27 the Washington state health insurance pool, and persons acting at the
28 direction of or on behalf of a carrier or the pool, who are in receipt
29 of an enrollee's or applicant's personally identifiable health
30 information included in the standard health questionnaire shall not
31 disclose the identifiable health information unless release of the
32 information is explicitly authorized in writing by the person who is
33 the subject of the information.

34 **Sec. 21.** RCW 48.43.025 and 1995 c 265 s 6 are each amended to read
35 as follows:

36 (1) For group health benefit plans, no carrier may reject an
37 individual for health plan coverage based upon preexisting conditions
38 of the individual and no carrier may deny, exclude, or otherwise limit

1 coverage for an individual's preexisting health conditions; except that
2 a carrier may impose a (~~three-month~~) nine-month benefit waiting
3 period for preexisting conditions for which medical advice was given,
4 (~~or~~) for which a health care provider recommended or provided
5 treatment, or for which a prudent layperson would have sought advice or
6 treatment, within (~~three~~) six months before the effective date of
7 coverage.

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

16 **Sec. 22.** RCW 48.43.035 and 1995 c 265 s 7 are each amended to read
17 as follows:

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

19 (1) All health carriers shall accept for enrollment any state
20 resident within the carrier's service area and provide or assure the
21 provision of all covered services regardless of age, sex, family
22 structure, ethnicity, race, health condition, geographic location,
23 employment status, socioeconomic status, other condition or situation,
24 or the provisions of RCW 49.60.174(2). The insurance commissioner may
25 grant a temporary exemption from this subsection, if, upon application
26 by a health carrier the commissioner finds that the clinical,
27 financial, or administrative capacity to serve existing enrollees will
28 be impaired if a health carrier is required to continue enrollment of
29 additional eligible individuals.

30 (2) Except as provided in subsection (5) of this section, all
31 health plans shall contain or incorporate by endorsement a guarantee of
32 the continuity of coverage of the plan. For the purposes of this
33 section, a plan is "renewed" when it is continued beyond the earliest
34 date upon which, at the carrier's sole option, the plan could have been
35 terminated for other than nonpayment of premium. In the case of group
36 plans, the carrier may consider the group's anniversary date as the
37 renewal date for purposes of complying with the provisions of this
38 section.

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

4 (a) Nonpayment of premium;

5 (b) Violation of published policies of the carrier approved by the
6 insurance commissioner;

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

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

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

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

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

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

20 (a) A carrier has zero enrollment on a product; or

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

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

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

36 NEW SECTION. Sec. 23. A new section is added to chapter 48.43 RCW
37 to read as follows:

1 (1) Except as provided in subsection (4) of this section, all
2 individual health plans shall contain or incorporate by endorsement a
3 guarantee of the continuity of coverage of the plan. For the purposes
4 of this section, a plan is "renewed" when it is continued beyond the
5 earliest date upon which, at the carrier's sole option, the plan could
6 have been terminated for other than nonpayment of premium.

7 (2) The guarantee of continuity of coverage required in individual
8 health plans shall not prevent a carrier from canceling or nonrenewing
9 a health plan for:

10 (a) Nonpayment of premium;

11 (b) Violation of published policies of the carrier approved by the
12 commissioner;

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

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

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

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

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

24 (3) This section does not apply in the following cases:

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

26 (b) A carrier is withdrawing from a service area or from a segment
27 of its service area because the carrier has demonstrated to the
28 commissioner that the carrier's clinical, financial, or administrative
29 capacity to serve enrollees would be exceeded;

30 (c) A carrier discontinues offering a particular type of health
31 benefit plan offered in the individual market if: (i) The carrier
32 provides notice to each covered individual provided coverage of this
33 type of such discontinuation at least ninety days prior to the date of
34 the discontinuation; (ii) the carrier offers to each individual
35 provided coverage of this type the option, without being subject to the
36 standard health questionnaire, to enroll in any other individual health
37 benefit plan currently being offered by the carrier; and (iii) in
38 exercising the option to discontinue coverage of this type and in
39 offering the option of coverage under (c)(ii) of this subsection, the

1 carrier acts uniformly without regard to any health status-related
2 factor of enrolled individuals or individuals who may become eligible
3 for such coverage; or

4 (d) A carrier discontinues offering all individual health coverage
5 in the state and discontinues coverage under all existing individual
6 health benefit plans if: (i) The carrier provides notice to the
7 commissioner of its intent to discontinue offering all individual
8 health coverage in the state and its intent to discontinue coverage
9 under all existing health benefit plans at least one hundred eighty
10 days prior to the date of the discontinuation of coverage under all
11 existing health benefit plans; and (ii) the carrier provides notice to
12 each covered individual of the intent to discontinue his or her
13 existing health benefit plan at least one hundred eighty days prior to
14 the date of such discontinuation. In the case of discontinuation under
15 this subsection, the carrier may not issue any individual health
16 coverage in this state for a five-year period beginning on the date of
17 the discontinuation of the last health plan not so renewed. Nothing in
18 this subsection (3) shall be construed to require a carrier to provide
19 notice to the commissioner of its intent to discontinue offering a
20 health benefit plan to new applicants where the carrier does not
21 discontinue coverage of existing enrollees under that health benefit
22 plan.

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

27 NEW SECTION. **Sec. 24.** A new section is added to chapter 48.43 RCW
28 to read as follows:

29 On or after January 1, 2001, all individual health benefit plans,
30 other than catastrophic health benefit plans, shall include benefits
31 described in this section. Nothing in this section shall be construed
32 to require a carrier to offer individual coverage.

33 (1) Maternity services that include, with no enrollee cost-sharing
34 requirements beyond those generally applicable cost sharing
35 requirements and those cost sharing requirements that apply to
36 preexisting conditions: Diagnosis of pregnancy; prenatal care;
37 delivery; care for complications of pregnancy; physician services;
38 hospital services; operating or other special procedure rooms;

1 radiology and laboratory services; appropriate medications; anesthesia;
2 and services required under RCW 48.43.115; and

3 (2) Prescription drug benefits with at least a two thousand dollar
4 benefit payable by the carrier annually.

5 NEW SECTION. **Sec. 25.** A new section is added to chapter 48.46 RCW
6 to read as follows:

7 Notwithstanding the provisions of this chapter, a health
8 maintenance organization may offer catastrophic health plans as defined
9 in RCW 48.43.005.

10 **Sec. 26.** RCW 48.44.020 and 1990 c 120 s 5 are each amended to read
11 as follows:

12 (1) Any health care service contractor may enter into contracts
13 with or for the benefit of persons or groups of persons which require
14 prepayment for health care services by or for such persons in
15 consideration of such health care service contractor providing one or
16 more health care services to such persons and such activity shall not
17 be subject to the laws relating to insurance if the health care
18 services are rendered by the health care service contractor or by a
19 participating provider.

20 (2) The commissioner may on examination, subject to the right of
21 the health care service contractor to demand and receive a hearing
22 under chapters 48.04 and 34.05 RCW, disapprove any individual or group
23 contract form for any of the following grounds:

24 (a) If it contains or incorporates by reference any inconsistent,
25 ambiguous or misleading clauses, or exceptions and conditions which
26 unreasonably or deceptively affect the risk purported to be assumed in
27 the general coverage of the contract; or

28 (b) If it has any title, heading, or other indication of its
29 provisions which is misleading; or

30 (c) If purchase of health care services thereunder is being
31 solicited by deceptive advertising; or

32 (~~(d) ((If, the benefits provided therein are unreasonable in
33 relation to the amount charged for the contract;~~

34 ~~(e)))~~ If it contains unreasonable restrictions on the treatment of
35 patients; or

36 ~~((f)))~~ (e) If it violates any provision of this chapter; or

1 (~~(g)~~) (f) If it fails to conform to minimum provisions or
2 standards required by regulation made by the commissioner pursuant to
3 chapter 34.05 RCW; or

4 (~~(h)~~) (g) If any contract for health care services with any state
5 agency, division, subdivision, board, or commission or with any
6 political subdivision, municipal corporation, or quasi-municipal
7 corporation fails to comply with state law.

8 (3) In addition to the grounds listed in subsection (2) of this
9 section, the commissioner may disapprove any group contract if the
10 benefits provided therein are unreasonable in relation to the amount
11 charged for the contract.

12 (4)(a) Every contract between a health care service contractor and
13 a participating provider of health care services shall be in writing
14 and shall state that in the event the health care service contractor
15 fails to pay for health care services as provided in the contract, the
16 enrolled participant shall not be liable to the provider for sums owed
17 by the health care service contractor. Every such contract shall
18 provide that this requirement shall survive termination of the
19 contract.

20 (b) No participating provider, agent, trustee, or assignee may
21 maintain any action against an enrolled participant to collect sums
22 owed by the health care service contractor.

23 NEW SECTION. Sec. 27. A new section is added to chapter 48.44 RCW
24 to read as follows:

25 (1) The definitions in this subsection apply throughout this
26 section unless the context clearly requires otherwise.

27 (a) "Claims" means the cost to the health care service contractor
28 of health care services, as defined in RCW 48.43.005, provided to a
29 contract holder or paid to or on behalf of a contract holder in
30 accordance with the terms of a health benefit plan, as defined in RCW
31 48.43.005. This includes capitation payments or other similar payments
32 made to providers for the purpose of paying for health care services
33 for an enrollee.

34 (b) "Claims reserves" means: (i) The liability for claims which
35 have been reported but not paid; (ii) the liability for claims which
36 have not been reported but which may reasonably be expected; (iii)
37 active life reserves; and (iv) additional claims reserves whether for
38 a specific liability purpose or not.

1 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,
2 plus any rate credits or recouplements less any refunds, for the
3 applicable period, whether received before, during, or after the
4 applicable period.

5 (d) "Incurred claims expense" means claims paid during the
6 applicable period plus any increase, or less any decrease, in the
7 claims reserves.

8 (e) "Loss ratio" means incurred claims expense as a percentage of
9 earned premiums.

10 (f) "Premiums earned" means premiums, as defined in RCW 48.43.005
11 plus any rate credits or recouplements less any refunds for the
12 applicable period whether received before, during, or after the
13 applicable period.

14 (g) "Reserves" means: (i) Active life reserves; and (ii)
15 additional reserves whether for a specific liability purpose or not.

16 (2) A health care service contractor shall file, for informational
17 purposes only, a notice of its schedule of rates for its individual
18 contracts with the commissioner prior to use.

19 (3) A health care service contractor shall file with the notice
20 required under subsection (2) of this section supporting documentation
21 of its method of determining the rates charged. The commissioner may
22 request only the following supporting documentation:

23 (a) A description of the health care service contractor's rate-
24 making methodology;

25 (b) An actuarially determined estimate of incurred claims which
26 includes the experience data, assumptions, and justifications of the
27 health care service contractor's projection;

28 (c) The percentage of premium attributable in aggregate for
29 nonclaims expenses used to determine the adjusted community rates
30 charged; and

31 (d) A certification by a member of the American academy of
32 actuaries, or other person acceptable to the commissioner, that the
33 adjusted community rate charged can be reasonably expected to result in
34 a loss ratio that meets or exceeds the loss ratio standard established
35 in subsection (7) of this section.

36 (4) The commissioner may not disapprove or otherwise impede the
37 implementation of the filed rates.

38 (5) By the last day of May each year any health care service
39 contractor providing individual health benefit plans in this state

1 shall file for review by the commissioner supporting documentation of
2 its actual loss ratio for its individual health benefit plans offered
3 in this state in aggregate for the preceding calendar year. The filing
4 shall include a certification by a member of the American academy of
5 actuaries, or other person acceptable to the commissioner, that the
6 actual loss ratio has been calculated in accordance with accepted
7 actuarial principles.

8 (a) At the expiration of a thirty-day period commencing with the
9 date the filing is delivered to the commissioner, the filing shall be
10 deemed approved unless prior thereto the commissioner contests the
11 calculation of the actual loss ratio.

12 (b) If the commissioner contests the calculation of the actual loss
13 ratio, the commissioner shall state in writing the grounds for
14 contesting the calculation to the health care service contractor.

15 (c) Any dispute regarding the calculation of the actual loss ratio
16 shall upon written demand of either the commissioner or the health care
17 service contractor be submitted to hearing under chapters 48.04 and
18 34.05 RCW.

19 (6) If the actual loss ratio for the preceding calendar year is
20 less than the loss ratio standard established in subsection (7) of this
21 section, refunds are due and the following shall apply:

22 (a) The health care service contractor shall calculate a percentage
23 of premium to be remitted to the Washington state health insurance pool
24 by subtracting the actual loss ratio for the preceding year from the
25 loss ratio established in subsection (7) of this section.

26 (b) The remittance to the Washington state health insurance pool is
27 the percentage calculated in (a) of this subsection, multiplied by the
28 premium earned from each enrollee in the previous calendar year.
29 Interest shall be added to the remittance due at a five percent annual
30 rate calculated from the end of the calendar year for which remittances
31 are due to the date the remittances are made.

32 (c) All remittances shall be aggregated and such amounts shall be
33 remitted to the Washington state high risk pool to be used as directed
34 by the pool board of directors.

35 (d) Any remittance required to be issued under this section shall
36 be issued within thirty days after the actual loss ratio is deemed
37 approved under subsection (5)(a) of this section or the determination
38 by an administrative law judge under subsection (5)(c) of this section.

1 (7) The loss ratio applicable to this section shall be seventy-four
2 percent minus the premium tax rate applicable to the health care
3 service contractor's individual health benefit plans under RCW
4 48.14.0201.

5 **Sec. 28.** RCW 48.44.022 and 1997 c 231 s 208 are each amended to
6 read as follows:

7 ~~(1)((a) A health care service contractor offering any health~~
8 ~~benefit plan to any individual shall offer and actively market to all~~
9 ~~individuals a health benefit plan providing benefits identical to the~~
10 ~~schedule of covered health benefits that are required to be delivered~~
11 ~~to an individual enrolled in the basic health plan, subject to the~~
12 ~~provisions in RCW 48.43.025 and 48.43.035. Nothing in this subsection~~
13 ~~shall preclude a contractor from offering, or an individual from~~
14 ~~purchasing, other health benefit plans that may have more or less~~
15 ~~comprehensive benefits than the basic health plan, provided such plans~~
16 ~~are in accordance with this chapter. A contractor offering a health~~
17 ~~benefit plan that does not include benefits provided in the basic~~
18 ~~health plan shall clearly disclose these differences to the individual~~
19 ~~in a brochure approved by the commissioner.~~

20 ~~(b) A health benefit plan shall provide coverage for hospital~~
21 ~~expenses and services rendered by a physician licensed under chapter~~
22 ~~18.57 or 18.71 RCW but is not subject to the requirements of RCW~~
23 ~~48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310,~~
24 ~~48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344,~~
25 ~~48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if the health~~
26 ~~benefit plan is the mandatory offering under (a) of this subsection~~
27 ~~that provides benefits identical to the basic health plan, to the~~
28 ~~extent these requirements differ from the basic health plan.~~

29 ~~(2))~~ Premium rates for health benefit plans for individuals shall
30 be subject to the following provisions:

31 (a) The health care service contractor shall develop its rates
32 based on an adjusted community rate and may only vary the adjusted
33 community rate for:

- 34 (i) Geographic area;
- 35 (ii) Family size;
- 36 (iii) Age;
- 37 (iv) Tenure discounts; and
- 38 (v) Wellness activities.

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

5 (c) The health care service contractor shall be permitted to
6 develop separate rates for individuals age sixty-five or older for
7 coverage for which medicare is the primary payer and coverage for which
8 medicare is not the primary payer. Both rates shall be subject to the
9 requirements of this subsection.

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

14 (e) A discount for wellness activities shall be permitted to
15 reflect actuarially justified differences in utilization or cost
16 attributed to such programs not to exceed twenty percent.

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

20 (i) Changes to the family composition;

21 (ii) Changes to the health benefit plan requested by the
22 individual; or

23 (iii) Changes in government requirements affecting the health
24 benefit plan.

25 (g) For the purposes of this section, a health benefit plan that
26 contains a restricted network provision shall not be considered similar
27 coverage to a health benefit plan that does not contain such a
28 provision, provided that the restrictions of benefits to network
29 providers result in substantial differences in claims costs. This
30 subsection does not restrict or enhance the portability of benefits as
31 provided in RCW 48.43.015.

32 (h) A tenure discount for continuous enrollment in the health plan
33 of two years or more may be offered, not to exceed ten percent.

34 ~~((+3))~~ (2) Adjusted community rates established under this section
35 shall pool the medical experience of all individuals purchasing
36 coverage, and shall not be required to be pooled with the medical
37 experience of health benefit plans offered to small employers under RCW
38 48.44.023.

1 (~~(4)~~) (3) As used in this section and RCW 48.44.023 "health
2 benefit plan," "small employer," (~~("basic health plan,"~~) "adjusted
3 community rates," and "wellness activities" mean the same as defined in
4 RCW 48.43.005.

5 **Sec. 29.** RCW 48.46.060 and 1989 c 10 s 10 are each amended to read
6 as follows:

7 (1) Any health maintenance organization may enter into agreements
8 with or for the benefit of persons or groups of persons, which require
9 prepayment for health care services by or for such persons in
10 consideration of the health maintenance organization providing health
11 care services to such persons. Such activity is not subject to the
12 laws relating to insurance if the health care services are rendered
13 directly by the health maintenance organization or by any provider
14 which has a contract or other arrangement with the health maintenance
15 organization to render health services to enrolled participants.

16 (2) All forms of health maintenance agreements issued by the
17 organization to enrolled participants or other marketing documents
18 purporting to describe the organization's comprehensive health care
19 services shall comply with such minimum standards as the commissioner
20 deems reasonable and necessary in order to carry out the purposes and
21 provisions of this chapter, and which fully inform enrolled
22 participants of the health care services to which they are entitled,
23 including any limitations or exclusions thereof, and such other rights,
24 responsibilities and duties required of the contracting health
25 maintenance organization.

26 (3) Subject to the right of the health maintenance organization to
27 demand and receive a hearing under chapters 48.04 and 34.05 RCW, the
28 commissioner may disapprove an individual or group agreement form for
29 any of the following grounds:

30 (a) If it contains or incorporates by reference any inconsistent,
31 ambiguous, or misleading clauses, or exceptions or conditions which
32 unreasonably or deceptively affect the risk purported to be assumed in
33 the general coverage of the agreement;

34 (b) If it has any title, heading, or other indication which is
35 misleading;

36 (c) If purchase of health care services thereunder is being
37 solicited by deceptive advertising;

1 (d) (~~(If the benefits provided therein are unreasonable in relation~~
2 ~~to the amount charged for the agreement;~~

3 ~~(e))~~ If it contains unreasonable restrictions on the treatment of
4 patients;

5 (~~(f))~~ (e) If it is in any respect in violation of this chapter or
6 if it fails to conform to minimum provisions or standards required by
7 the commissioner by rule under chapter 34.05 RCW; or

8 (~~(g))~~ (f) If any agreement for health care services with any
9 state agency, division, subdivision, board, or commission or with any
10 political subdivision, municipal corporation, or quasi-municipal
11 corporation fails to comply with state law.

12 (4) In addition to the grounds listed in subsection (2) of this
13 section, the commissioner may disapprove any group agreement if the
14 benefits provided therein are unreasonable in relation to the amount
15 charged for the agreement.

16 (5) No health maintenance organization authorized under this
17 chapter shall cancel or fail to renew the enrollment on any basis of an
18 enrolled participant or refuse to transfer an enrolled participant from
19 a group to an individual basis for reasons relating solely to age, sex,
20 race, or health status(~~(:—PROVIDED HOWEVER, That)~~). Nothing contained
21 herein shall prevent cancellation of an agreement with enrolled
22 participants (a) who violate any published policies of the organization
23 which have been approved by the commissioner, or (b) who are entitled
24 to become eligible for medicare benefits and fail to enroll for a
25 medicare supplement plan offered by the health maintenance organization
26 and approved by the commissioner, or (c) for failure of such enrolled
27 participant to pay the approved charge, including cost-sharing,
28 required under such contract, or (d) for a material breach of the
29 health maintenance agreement.

30 (~~(5))~~ (6) No agreement form or amendment to an approved agreement
31 form shall be used unless it is first filed with the commissioner.

32 NEW SECTION. Sec. 30. A new section is added to chapter 48.46 RCW
33 to read as follows:

34 (1) The definitions in this subsection apply throughout this
35 section unless the context clearly requires otherwise.

36 (a) "Claims" means the cost to the health maintenance organization
37 of health care services, as defined in RCW 48.43.005, provided to an
38 enrollee or paid to or on behalf of the enrollee in accordance with the

1 terms of a health benefit plan, as defined in RCW 48.43.005. This
2 includes capitation payments or other similar payments made to
3 providers for the purpose of paying for health care services for an
4 enrollee.

5 (b) "Claims reserves" means: (i) The liability for claims which
6 have been reported but not paid; (ii) the liability for claims which
7 have not been reported but which may reasonably be expected; (iii)
8 active life reserves; and (iv) additional claims reserves whether for
9 a specific liability purpose or not.

10 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,
11 plus any rate credits or recoupments less any refunds, for the
12 applicable period, whether received before, during, or after the
13 applicable period.

14 (d) "Incurred claims expense" means claims paid during the
15 applicable period plus any increase, or less any decrease, in the
16 claims reserves.

17 (e) "Loss ratio" means incurred claims expense as a percentage of
18 earned premiums.

19 (f) "Premiums earned" means premiums, as defined in RCW 48.43.005
20 plus any rate credits or recoupments less any refunds for the
21 applicable period whether received before, during, or after the
22 applicable period.

23 (g) "Reserves" means: (i) Active life reserves; and (ii)
24 additional reserves whether for a specific liability purpose or not.

25 (2) A health maintenance organization shall file, for informational
26 purposes only, a notice of its schedule of rates for its individual
27 agreements with the commissioner prior to use.

28 (3) A health maintenance organization shall file with the notice
29 required under subsection (2) of this section supporting documentation
30 of its method of determining the rates charged. The commissioner may
31 request only the following supporting documentation:

32 (a) A description of the health maintenance organization's rate-
33 making methodology;

34 (b) An actuarially determined estimate of incurred claims which
35 includes the experience data, assumptions, and justifications of the
36 health maintenance organization's projection;

37 (c) The percentage of premium attributable in aggregate for
38 nonclaims expenses used to determine the adjusted community rates
39 charged; and

1 (d) A certification by a member of the American academy of
2 actuaries, or other person acceptable to the commissioner, that the
3 adjusted community rate charged can be reasonably expected to result in
4 a loss ratio that meets or exceeds the loss ratio standard established
5 in subsection (7) of this section.

6 (4) The commissioner may not disapprove or otherwise impede the
7 implementation of the filed rates.

8 (5) By the last day of May each year any health maintenance
9 organization providing individual health benefit plans in this state
10 shall file for review by the commissioner supporting documentation of
11 its actual loss ratio for its individual health benefit plans offered
12 in the state in aggregate for the preceding calendar year. The filing
13 shall include a certification by a member of the American academy of
14 actuaries, or other person acceptable to the commissioner, that the
15 actual loss ratio has been calculated in accordance with accepted
16 actuarial principles.

17 (a) At the expiration of a thirty-day period commencing with the
18 date the filing is delivered to the commissioner, the filing shall be
19 deemed approved unless prior thereto the commissioner contests the
20 calculation of the actual loss ratio.

21 (b) If the commissioner contests the calculation of the actual loss
22 ratio, the commissioner shall state in writing the grounds for
23 contesting the calculation to the health maintenance organization.

24 (c) Any dispute regarding the calculation of the actual loss ratio
25 shall, upon written demand of either the commissioner or the health
26 maintenance organization, be submitted to hearing under chapters 48.04
27 and 34.05 RCW.

28 (6) If the actual loss ratio for the preceding calendar year is
29 less than the loss ratio standard established in subsection (7) of this
30 section, refunds are due and the following shall apply:

31 (a) The health maintenance organization shall calculate a
32 percentage of premium to be remitted to the Washington state health
33 insurance pool by subtracting the actual loss ratio for the preceding
34 year from the loss ratio established in subsection (7) of this section.

35 (b) The remittance to the Washington state health insurance pool is
36 the percentage calculated in (a) of this subsection, multiplied by the
37 premium earned from each enrollee in the previous calendar year.
38 Interest shall be added to the remittance due at a five percent annual

1 rate calculated from the end of the calendar year for which remittances
2 are due to the date the remittances are made.

3 (c) All remittances shall be aggregated and such amounts shall be
4 remitted to the Washington state high risk pool to be used as directed
5 by the pool board of directors.

6 (d) Any remittance required to be issued under this section shall
7 be issued within thirty days after the actual loss ratio is deemed
8 approved under subsection (5)(a) of this section or the determination
9 by an administrative law judge under subsection (5)(c) of this section.

10 (7) The loss ratio applicable to this section shall be seventy-four
11 percent minus the premium tax rate applicable to the health maintenance
12 organization's individual health benefit plans under RCW 48.14.0201.

13 **Sec. 31.** RCW 48.46.064 and 1997 c 231 s 209 are each amended to
14 read as follows:

15 ~~(1)((a) A health maintenance organization offering any health
16 benefit plan to any individual shall offer and actively market to all
17 individuals a health benefit plan providing benefits identical to the
18 schedule of covered health benefits that are required to be delivered
19 to an individual enrolled in the basic health plan, subject to the
20 provisions in RCW 48.43.025 and 48.43.035. Nothing in this subsection
21 shall preclude a health maintenance organization from offering, or an
22 individual from purchasing, other health benefit plans that may have
23 more or less comprehensive benefits than the basic health plan,
24 provided such plans are in accordance with this chapter. A health
25 maintenance organization offering a health benefit plan that does not
26 include benefits provided in the basic health plan shall clearly
27 disclose these differences to the individual in a brochure approved by
28 the commissioner.~~

29 ~~(b) A health benefit plan shall provide coverage for hospital
30 expenses and services rendered by a physician licensed under chapter
31 18.57 or 18.71 RCW but is not subject to the requirements of RCW
32 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355,
33 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if
34 the health benefit plan is the mandatory offering under (a) of this
35 subsection that provides benefits identical to the basic health plan,
36 to the extent these requirements differ from the basic health plan.~~

37 ~~(2))~~ Premium rates for health benefit plans for individuals shall
38 be subject to the following provisions:

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

- 4 (i) Geographic area;
- 5 (ii) Family size;
- 6 (iii) Age;
- 7 (iv) Tenure discounts; and
- 8 (v) Wellness activities.

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

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

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

22 (e) A discount for wellness activities shall be permitted to
23 reflect actuarially justified differences in utilization or cost
24 attributed to such programs not to exceed twenty percent.

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

- 28 (i) Changes to the family composition;
- 29 (ii) Changes to the health benefit plan requested by the
30 individual; or
- 31 (iii) Changes in government requirements affecting the health
32 benefit plan.

33 (g) For the purposes of this section, a health benefit plan that
34 contains a restricted network provision shall not be considered similar
35 coverage to a health benefit plan that does not contain such a
36 provision, provided that the restrictions of benefits to network
37 providers result in substantial differences in claims costs. This
38 subsection does not restrict or enhance the portability of benefits as
39 provided in RCW 48.43.015.

1 (h) A tenure discount for continuous enrollment in the health plan
2 of two years or more may be offered, not to exceed ten percent.

3 ((+3)) (2) Adjusted community rates established under this section
4 shall pool the medical experience of all individuals purchasing
5 coverage, and shall not be required to be pooled with the medical
6 experience of health benefit plans offered to small employers under RCW
7 48.46.066.

8 ((+4)) (3) As used in this section and RCW 48.46.066, "health
9 benefit plan," (~~("basic health plan,"~~) "adjusted community rate,"
10 "small employer," and "wellness activities" mean the same as defined in
11 RCW 48.43.005.

12 **Sec. 32.** RCW 70.47.060 and 1998 c 314 s 17 and 1998 c 148 s 1 are
13 each reenacted and amended to read as follows:

14 The administrator has the following powers and duties:

15 (1) To design and from time to time revise a schedule of covered
16 basic health care services, including physician services, inpatient and
17 outpatient hospital services, prescription drugs and medications, and
18 other services that may be necessary for basic health care. In
19 addition, the administrator may, to the extent that funds are
20 available, offer as basic health plan services chemical dependency
21 services, mental health services and organ transplant services;
22 however, no one service or any combination of these three services
23 shall increase the actuarial value of the basic health plan benefits by
24 more than five percent excluding inflation, as determined by the office
25 of financial management. All subsidized and nonsubsidized enrollees in
26 any participating managed health care system under the Washington basic
27 health plan shall be entitled to receive covered basic health care
28 services in return for premium payments to the plan. The schedule of
29 services shall emphasize proven preventive and primary health care and
30 shall include all services necessary for prenatal, postnatal, and well-
31 child care. However, with respect to coverage for groups of subsidized
32 enrollees who are eligible to receive prenatal and postnatal services
33 through the medical assistance program under chapter 74.09 RCW, the
34 administrator shall not contract for such services except to the extent
35 that such services are necessary over not more than a one-month period
36 in order to maintain continuity of care after diagnosis of pregnancy by
37 the managed care provider. The schedule of services shall also include
38 a separate schedule of basic health care services for children,

1 eight years of age and younger, for those subsidized or
2 nonsubsidized enrollees who choose to secure basic coverage through the
3 plan only for their dependent children. In designing and revising the
4 schedule of services, the administrator shall consider the guidelines
5 for assessing health services under the mandated benefits act of 1984,
6 RCW 48.47.030, and such other factors as the administrator deems
7 appropriate.

8 However, with respect to coverage for subsidized enrollees who are
9 eligible to receive prenatal and postnatal services through the medical
10 assistance program under chapter 74.09 RCW, the administrator shall not
11 contract for such services except to the extent that the services are
12 necessary over not more than a one-month period in order to maintain
13 continuity of care after diagnosis of pregnancy by the managed care
14 provider.

15 (2)(a) To design and implement a structure of periodic premiums due
16 the administrator from subsidized enrollees that is based upon gross
17 family income, giving appropriate consideration to family size and the
18 ages of all family members. The enrollment of children shall not
19 require the enrollment of their parent or parents who are eligible for
20 the plan. The structure of periodic premiums shall be applied to
21 subsidized enrollees entering the plan as individuals pursuant to
22 subsection (9) of this section and to the share of the cost of the plan
23 due from subsidized enrollees entering the plan as employees pursuant
24 to subsection (10) of this section.

25 (b) To determine the periodic premiums due the administrator from
26 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
27 shall be in an amount equal to the cost charged by the managed health
28 care system provider to the state for the plan plus the administrative
29 cost of providing the plan to those enrollees and the premium tax under
30 RCW 48.14.0201.

31 (c) An employer or other financial sponsor may, with the prior
32 approval of the administrator, pay the premium, rate, or any other
33 amount on behalf of a subsidized or nonsubsidized enrollee, by
34 arrangement with the enrollee and through a mechanism acceptable to the
35 administrator.

36 (d) To develop, as an offering by every health carrier providing
37 coverage identical to the basic health plan, as configured on January
38 1, 1996, a basic health plan model plan with uniformity in enrollee
39 cost-sharing requirements.

1 (3) To design and implement a structure of enrollee cost sharing
2 due a managed health care system from subsidized and nonsubsidized
3 enrollees. The structure shall discourage inappropriate enrollee
4 utilization of health care services, and may utilize copayments,
5 deductibles, and other cost-sharing mechanisms, but shall not be so
6 costly to enrollees as to constitute a barrier to appropriate
7 utilization of necessary health care services.

8 (4) To limit enrollment of persons who qualify for subsidies so as
9 to prevent an overexpenditure of appropriations for such purposes.
10 Whenever the administrator finds that there is danger of such an
11 overexpenditure, the administrator shall close enrollment until the
12 administrator finds the danger no longer exists.

13 (5) To limit the payment of subsidies to subsidized enrollees, as
14 defined in RCW 70.47.020. The level of subsidy provided to persons who
15 qualify may be based on the lowest cost plans, as defined by the
16 administrator.

17 (6) To adopt a schedule for the orderly development of the delivery
18 of services and availability of the plan to residents of the state,
19 subject to the limitations contained in RCW 70.47.080 or any act
20 appropriating funds for the plan.

21 (7) To solicit and accept applications from managed health care
22 systems, as defined in this chapter, for inclusion as eligible basic
23 health care providers under the plan for either subsidized enrollees,
24 or nonsubsidized enrollees, or both. The administrator shall endeavor
25 to assure that covered basic health care services are available to any
26 enrollee of the plan from among a selection of two or more
27 participating managed health care systems. In adopting any rules or
28 procedures applicable to managed health care systems and in its
29 dealings with such systems, the administrator shall consider and make
30 suitable allowance for the need for health care services and the
31 differences in local availability of health care resources, along with
32 other resources, within and among the several areas of the state.
33 Contracts with participating managed health care systems shall ensure
34 that basic health plan enrollees who become eligible for medical
35 assistance may, at their option, continue to receive services from
36 their existing providers within the managed health care system if such
37 providers have entered into provider agreements with the department of
38 social and health services.

1 (8) To receive periodic premiums from or on behalf of subsidized
2 and nonsubsidized enrollees, deposit them in the basic health plan
3 operating account, keep records of enrollee status, and authorize
4 periodic payments to managed health care systems on the basis of the
5 number of enrollees participating in the respective managed health care
6 systems.

7 (9) To accept applications from individuals residing in areas
8 served by the plan, on behalf of themselves and their spouses and
9 dependent children, for enrollment in the Washington basic health plan
10 as subsidized or nonsubsidized enrollees, to establish appropriate
11 minimum-enrollment periods for enrollees as may be necessary, and to
12 determine, upon application and on a reasonable schedule defined by the
13 authority, or at the request of any enrollee, eligibility due to
14 current gross family income for sliding scale premiums. Funds received
15 by a family as part of participation in the adoption support program
16 authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall
17 not be counted toward a family's current gross family income for the
18 purposes of this chapter. When an enrollee fails to report income or
19 income changes accurately, the administrator shall have the authority
20 either to bill the enrollee for the amounts overpaid by the state or to
21 impose civil penalties of up to two hundred percent of the amount of
22 subsidy overpaid due to the enrollee incorrectly reporting income. The
23 administrator shall adopt rules to define the appropriate application
24 of these sanctions and the processes to implement the sanctions
25 provided in this subsection, within available resources. No subsidy
26 may be paid with respect to any enrollee whose current gross family
27 income exceeds twice the federal poverty level or, subject to RCW
28 70.47.110, who is a recipient of medical assistance or medical care
29 services under chapter 74.09 RCW. If a number of enrollees drop their
30 enrollment for no apparent good cause, the administrator may establish
31 appropriate rules or requirements that are applicable to such
32 individuals before they will be allowed to reenroll in the plan.

33 (10) To accept applications from business owners on behalf of
34 themselves and their employees, spouses, and dependent children, as
35 subsidized or nonsubsidized enrollees, who reside in an area served by
36 the plan. The administrator may require all or the substantial
37 majority of the eligible employees of such businesses to enroll in the
38 plan and establish those procedures necessary to facilitate the orderly
39 enrollment of groups in the plan and into a managed health care system.

1 The administrator may require that a business owner pay at least an
2 amount equal to what the employee pays after the state pays its portion
3 of the subsidized premium cost of the plan on behalf of each employee
4 enrolled in the plan. Enrollment is limited to those not eligible for
5 medicare who wish to enroll in the plan and choose to obtain the basic
6 health care coverage and services from a managed care system
7 participating in the plan. The administrator shall adjust the amount
8 determined to be due on behalf of or from all such enrollees whenever
9 the amount negotiated by the administrator with the participating
10 managed health care system or systems is modified or the administrative
11 cost of providing the plan to such enrollees changes.

12 (11) To determine the rate to be paid to each participating managed
13 health care system in return for the provision of covered basic health
14 care services to enrollees in the system. Although the schedule of
15 covered basic health care services will be the same or actuarially
16 equivalent for similar enrollees, the rates negotiated with
17 participating managed health care systems may vary among the systems.
18 In negotiating rates with participating systems, the administrator
19 shall consider the characteristics of the populations served by the
20 respective systems, economic circumstances of the local area, the need
21 to conserve the resources of the basic health plan trust account, and
22 other factors the administrator finds relevant.

23 (12) To monitor the provision of covered services to enrollees by
24 participating managed health care systems in order to assure enrollee
25 access to good quality basic health care, to require periodic data
26 reports concerning the utilization of health care services rendered to
27 enrollees in order to provide adequate information for evaluation, and
28 to inspect the books and records of participating managed health care
29 systems to assure compliance with the purposes of this chapter. In
30 requiring reports from participating managed health care systems,
31 including data on services rendered enrollees, the administrator shall
32 endeavor to minimize costs, both to the managed health care systems and
33 to the plan. The administrator shall coordinate any such reporting
34 requirements with other state agencies, such as the insurance
35 commissioner and the department of health, to minimize duplication of
36 effort.

37 (13) To evaluate the effects this chapter has on private employer-
38 based health care coverage and to take appropriate measures consistent

1 with state and federal statutes that will discourage the reduction of
2 such coverage in the state.

3 (14) To develop a program of proven preventive health measures and
4 to integrate it into the plan wherever possible and consistent with
5 this chapter.

6 (15) To provide, consistent with available funding, assistance for
7 rural residents, underserved populations, and persons of color.

8 (16) In consultation with appropriate state and local government
9 agencies, to establish criteria defining eligibility for persons
10 confined or residing in government-operated institutions.

11 **Sec. 33.** RCW 70.47.100 and 1987 1st ex.s. c 5 s 12 are each
12 amended to read as follows:

13 (1) A managed health care (~~systems~~) system participating in the
14 plan shall do so by contract with the administrator and shall provide,
15 directly or by contract with other health care providers, covered basic
16 health care services to each enrollee covered by its contract with the
17 administrator as long as payments from the administrator on behalf of
18 the enrollee are current. A participating managed health care system
19 may offer, without additional cost, health care benefits or services
20 not included in the schedule of covered services under the plan. A
21 participating managed health care system shall not give preference in
22 enrollment to enrollees who accept such additional health care benefits
23 or services. Managed health care systems participating in the plan
24 shall not discriminate against any potential or current enrollee based
25 upon health status, sex, race, ethnicity, or religion. The
26 administrator may receive and act upon complaints from enrollees
27 regarding failure to provide covered services or efforts to obtain
28 payment, other than authorized copayments, for covered services
29 directly from enrollees, but nothing in this chapter empowers the
30 administrator to impose any sanctions under Title 18 RCW or any other
31 professional or facility licensing statute.

32 (2) The plan shall allow, at least annually, an opportunity for
33 enrollees to transfer their enrollments among participating managed
34 health care systems serving their respective areas. The administrator
35 shall establish a period of at least twenty days in a given year when
36 this opportunity is afforded enrollees, and in those areas served by
37 more than one participating managed health care system the
38 administrator shall endeavor to establish a uniform period for such

1 opportunity. The plan shall allow enrollees to transfer their
2 enrollment to another participating managed health care system at any
3 time upon a showing of good cause for the transfer.

4 ~~((Any contract between a hospital and a participating managed
5 health care system under this chapter is subject to the requirements of
6 RCW 70.39.140(1) regarding negotiated rates.))~~

7 (3) Prior to negotiating with any managed health care system, the
8 administrator shall determine, on an actuarially sound basis, the
9 reasonable cost of providing the schedule of basic health care
10 services, expressed in terms of upper and lower limits, and recognizing
11 variations in the cost of providing the services through the various
12 systems and in different areas of the state.

13 (4) In negotiating with managed health care systems for
14 participation in the plan, the administrator shall adopt a uniform
15 procedure that includes at least the following:

16 ~~((1))~~ (a) The administrator shall issue a request for proposals,
17 including standards regarding the quality of services to be provided;
18 financial integrity of the responding systems; and responsiveness to
19 the unmet health care needs of the local communities or populations
20 that may be served;

21 ~~((2))~~ (b) The administrator shall then review responsive
22 proposals and may negotiate with respondents to the extent necessary to
23 refine any proposals;

24 ~~((3))~~ (c) The administrator may then select one or more systems
25 to provide the covered services within a local area; and

26 ~~((4))~~ (d) The administrator may adopt a policy that gives
27 preference to respondents, such as nonprofit community health clinics,
28 that have a history of providing quality health care services to low-
29 income persons.

30 (5) The administrator may contract with a managed health care
31 system to provide covered basic health care services to either
32 subsidized enrollees, or nonsubsidized enrollees, or both.

33 (6) The administrator may establish procedures and policies to
34 further negotiate and contract with managed health care systems
35 following completion of the request for proposal process in subsection
36 (4) of this section, upon a determination by the administrator that it
37 is necessary to provide access to covered basic health care services
38 for enrollees.

1 (7) Until January 1, 2004, the administrator may utilize a self-
2 funded or self-insured method of providing insurance coverage to
3 subsidized enrollees provided under RCW 41.05.140 in a specific
4 geographic area if: (a) It is necessary to provide access to covered
5 basic health care services for subsidized enrollees; (b) funding for
6 adequate reserves is available in the basic health plan self-insurance
7 reserve account; (c) the administrator has received a certification
8 from a member of the American academy of actuaries that the funding
9 available in the basic health plan self-insurance reserve account is
10 sufficient for the self-funded or self-insured risk assumed, or
11 expected to be assumed, by the administrator; (d) the administrator
12 received no responsive proposals to the request for proposal process in
13 subsection (4) of this section for a specific geographic area; and (e)
14 other options for providing access to covered basic health care
15 services for subsidized enrollees are not feasible.

16 NEW SECTION. Sec. 34. A new section is added to chapter 48.41 RCW
17 to read as follows:

18 The Washington state health insurance pool account is created in
19 the custody of the state treasurer. All receipts from moneys
20 specifically appropriated to the account must be deposited in the
21 account. Expenditures from the account may be used only to cover
22 deficits incurred by the Washington state health insurance pool under
23 this chapter in excess of the threshold established in this section.
24 To the extent funds are available in the account, funds shall be
25 expended from the account only to offset that portion of the deficit
26 that would otherwise have to be recovered by imposing an assessment on
27 members in excess of a threshold of seventy cents per insured person
28 per month. The commissioner shall authorize expenditures from the
29 account, to the extent that funds are available in the account, upon
30 certification by the pool board that assessments will exceed the
31 threshold level established in this section. The account is subject to
32 the allotment procedures under chapter 43.88 RCW, but an appropriation
33 is not required for expenditures.

34 **Sec. 35.** RCW 43.84.092 and 1999 c 380 s 8, 1999 c 309 s 928, 1999
35 c 268 s 4, and 1999 c 94 s 2 are each reenacted and amended to read as
36 follows:

1 (1) All earnings of investments of surplus balances in the state
2 treasury shall be deposited to the treasury income account, which
3 account is hereby established in the state treasury.

4 (2) The treasury income account shall be utilized to pay or receive
5 funds associated with federal programs as required by the federal cash
6 management improvement act of 1990. The treasury income account is
7 subject in all respects to chapter 43.88 RCW, but no appropriation is
8 required for refunds or allocations of interest earnings required by
9 the cash management improvement act. Refunds of interest to the
10 federal treasury required under the cash management improvement act
11 fall under RCW 43.88.180 and shall not require appropriation. The
12 office of financial management shall determine the amounts due to or
13 from the federal government pursuant to the cash management improvement
14 act. The office of financial management may direct transfers of funds
15 between accounts as deemed necessary to implement the provisions of the
16 cash management improvement act, and this subsection. Refunds or
17 allocations shall occur prior to the distributions of earnings set
18 forth in subsection (4) of this section.

19 (3) Except for the provisions of RCW 43.84.160, the treasury income
20 account may be utilized for the payment of purchased banking services
21 on behalf of treasury funds including, but not limited to, depository,
22 safekeeping, and disbursement functions for the state treasury and
23 affected state agencies. The treasury income account is subject in all
24 respects to chapter 43.88 RCW, but no appropriation is required for
25 payments to financial institutions. Payments shall occur prior to
26 distribution of earnings set forth in subsection (4) of this section.

27 (4) Monthly, the state treasurer shall distribute the earnings
28 credited to the treasury income account. The state treasurer shall
29 credit the general fund with all the earnings credited to the treasury
30 income account except:

31 (a) The following accounts and funds shall receive their
32 proportionate share of earnings based upon each account's and fund's
33 average daily balance for the period: The capitol building
34 construction account, the Cedar River channel construction and
35 operation account, the Central Washington University capital projects
36 account, the charitable, educational, penal and reformatory
37 institutions account, the common school construction fund, the county
38 criminal justice assistance account, the county sales and use tax
39 equalization account, the data processing building construction

1 account, the deferred compensation administrative account, the deferred
2 compensation principal account, the department of retirement systems
3 expense account, the drinking water assistance account, the Eastern
4 Washington University capital projects account, the education
5 construction fund, the emergency reserve fund, the federal forest
6 revolving account, the health services account, the public health
7 services account, the health system capacity account, the personal
8 health services account, the state higher education construction
9 account, the higher education construction account, the highway
10 infrastructure account, the industrial insurance premium refund
11 account, the judges' retirement account, the judicial retirement
12 administrative account, the judicial retirement principal account, the
13 local leasehold excise tax account, the local real estate excise tax
14 account, the local sales and use tax account, the medical aid account,
15 the mobile home park relocation fund, the municipal criminal justice
16 assistance account, the municipal sales and use tax equalization
17 account, the natural resources deposit account, the perpetual
18 surveillance and maintenance account, the public employees' retirement
19 system plan 1 account, the public employees' retirement system plan 2
20 account, the Puyallup tribal settlement account, the resource
21 management cost account, the site closure account, the special wildlife
22 account, the state employees' insurance account, the state employees'
23 insurance reserve account, the state investment board expense account,
24 the state investment board commingled trust fund accounts, the
25 supplemental pension account, the teachers' retirement system plan 1
26 account, the teachers' retirement system plan 2 account, the tobacco
27 prevention and control account, the tobacco settlement account, the
28 transportation infrastructure account, the tuition recovery trust fund,
29 the University of Washington bond retirement fund, the University of
30 Washington building account, the volunteer fire fighters' and reserve
31 officers' relief and pension principal ((account)) fund, the volunteer
32 fire fighters' ((relief and pension)) and reserve officers'
33 administrative ((account)) fund, the Washington judicial retirement
34 system account, the Washington law enforcement officers' and fire
35 fighters' system plan 1 retirement account, the Washington law
36 enforcement officers' and fire fighters' system plan 2 retirement
37 account, the Washington state health insurance pool account, the
38 Washington state patrol retirement account, the Washington State
39 University building account, the Washington State University bond

1 retirement fund, the water pollution control revolving fund, and the
2 Western Washington University capital projects account. Earnings
3 derived from investing balances of the agricultural permanent fund, the
4 normal school permanent fund, the permanent common school fund, the
5 scientific permanent fund, and the state university permanent fund
6 shall be allocated to their respective beneficiary accounts. All
7 earnings to be distributed under this subsection (4)(a) shall first be
8 reduced by the allocation to the state treasurer's service fund
9 pursuant to RCW 43.08.190.

10 (b) The following accounts and funds shall receive eighty percent
11 of their proportionate share of earnings based upon each account's or
12 fund's average daily balance for the period: The aeronautics account,
13 the aircraft search and rescue account, the county arterial
14 preservation account, the department of licensing services account, the
15 essential rail assistance account, the ferry bond retirement fund, the
16 grade crossing protective fund, the high capacity transportation
17 account, the highway bond retirement fund, the highway safety account,
18 the marine operating fund, the motor vehicle fund, the motorcycle
19 safety education account, the pilotage account, the public
20 transportation systems account, the Puget Sound capital construction
21 account, the Puget Sound ferry operations account, the recreational
22 vehicle account, the rural arterial trust account, the safety and
23 education account, the special category C account, the state patrol
24 highway account, the transportation equipment fund, the transportation
25 fund, the transportation improvement account, the transportation
26 improvement board bond retirement account, and the urban arterial trust
27 account.

28 (5) In conformance with Article II, section 37 of the state
29 Constitution, no treasury accounts or funds shall be allocated earnings
30 without the specific affirmative directive of this section.

31 **Sec. 36.** RCW 43.84.092 and 1999 c 380 s 8, 1999 c 309 s 928, 1999
32 c 268 s 4, 1999 c 94 s 3, and 1999 c 94 s 2 are each reenacted and
33 amended to read as follows:

34 (1) All earnings of investments of surplus balances in the state
35 treasury shall be deposited to the treasury income account, which
36 account is hereby established in the state treasury.

37 (2) The treasury income account shall be utilized to pay or receive
38 funds associated with federal programs as required by the federal cash

1 management improvement act of 1990. The treasury income account is
2 subject in all respects to chapter 43.88 RCW, but no appropriation is
3 required for refunds or allocations of interest earnings required by
4 the cash management improvement act. Refunds of interest to the
5 federal treasury required under the cash management improvement act
6 fall under RCW 43.88.180 and shall not require appropriation. The
7 office of financial management shall determine the amounts due to or
8 from the federal government pursuant to the cash management improvement
9 act. The office of financial management may direct transfers of funds
10 between accounts as deemed necessary to implement the provisions of the
11 cash management improvement act, and this subsection. Refunds or
12 allocations shall occur prior to the distributions of earnings set
13 forth in subsection (4) of this section.

14 (3) Except for the provisions of RCW 43.84.160, the treasury income
15 account may be utilized for the payment of purchased banking services
16 on behalf of treasury funds including, but not limited to, depository,
17 safekeeping, and disbursement functions for the state treasury and
18 affected state agencies. The treasury income account is subject in all
19 respects to chapter 43.88 RCW, but no appropriation is required for
20 payments to financial institutions. Payments shall occur prior to
21 distribution of earnings set forth in subsection (4) of this section.

22 (4) Monthly, the state treasurer shall distribute the earnings
23 credited to the treasury income account. The state treasurer shall
24 credit the general fund with all the earnings credited to the treasury
25 income account except:

26 (a) The following accounts and funds shall receive their
27 proportionate share of earnings based upon each account's and fund's
28 average daily balance for the period: The capitol building
29 construction account, the Cedar River channel construction and
30 operation account, the Central Washington University capital projects
31 account, the charitable, educational, penal and reformatory
32 institutions account, the common school construction fund, the county
33 criminal justice assistance account, the county sales and use tax
34 equalization account, the data processing building construction
35 account, the deferred compensation administrative account, the deferred
36 compensation principal account, the department of retirement systems
37 expense account, the drinking water assistance account, the Eastern
38 Washington University capital projects account, the education
39 construction fund, the emergency reserve fund, the federal forest

1 revolving account, the health services account, the public health
2 services account, the health system capacity account, the personal
3 health services account, the state higher education construction
4 account, the higher education construction account, the highway
5 infrastructure account, the industrial insurance premium refund
6 account, the judges' retirement account, the judicial retirement
7 administrative account, the judicial retirement principal account, the
8 local leasehold excise tax account, the local real estate excise tax
9 account, the local sales and use tax account, the medical aid account,
10 the mobile home park relocation fund, the municipal criminal justice
11 assistance account, the municipal sales and use tax equalization
12 account, the natural resources deposit account, the perpetual
13 surveillance and maintenance account, the public employees' retirement
14 system plan 1 account, the public employees' retirement system plan 2
15 account, the Puyallup tribal settlement account, the resource
16 management cost account, the site closure account, the special wildlife
17 account, the state employees' insurance account, the state employees'
18 insurance reserve account, the state investment board expense account,
19 the state investment board commingled trust fund accounts, the
20 supplemental pension account, the teachers' retirement system plan 1
21 account, the teachers' retirement system plan 2 account, the tobacco
22 prevention and control account, the tobacco settlement account, the
23 transportation infrastructure account, the tuition recovery trust fund,
24 the University of Washington bond retirement fund, the University of
25 Washington building account, the volunteer fire fighters' and reserve
26 officers' relief and pension principal ((account)) fund, the volunteer
27 fire fighters' ((relief—and—pension)) and reserve officers'
28 administrative ((account)) fund, the Washington judicial retirement
29 system account, the Washington law enforcement officers' and fire
30 fighters' system plan 1 retirement account, the Washington law
31 enforcement officers' and fire fighters' system plan 2 retirement
32 account, the Washington state health insurance pool account, the
33 Washington state patrol retirement account, the Washington State
34 University building account, the Washington State University bond
35 retirement fund, the water pollution control revolving fund, and the
36 Western Washington University capital projects account. Earnings
37 derived from investing balances of the agricultural permanent fund, the
38 normal school permanent fund, the permanent common school fund, the
39 scientific permanent fund, and the state university permanent fund

1 shall be allocated to their respective beneficiary accounts. All
2 earnings to be distributed under this subsection (4)(a) shall first be
3 reduced by the allocation to the state treasurer's service fund
4 pursuant to RCW 43.08.190.

5 (b) The following accounts and funds shall receive eighty percent
6 of their proportionate share of earnings based upon each account's or
7 fund's average daily balance for the period: The aeronautics account,
8 the aircraft search and rescue account, the county arterial
9 preservation account, the department of licensing services account, the
10 essential rail assistance account, the ferry bond retirement fund, the
11 grade crossing protective fund, the high capacity transportation
12 account, the highway bond retirement fund, the highway safety account,
13 the motor vehicle fund, the motorcycle safety education account, the
14 pilotage account, the public transportation systems account, the Puget
15 Sound capital construction account, the Puget Sound ferry operations
16 account, the recreational vehicle account, the rural arterial trust
17 account, the safety and education account, the special category C
18 account, the state patrol highway account, the transportation equipment
19 fund, the transportation fund, the transportation improvement account,
20 the transportation improvement board bond retirement account, and the
21 urban arterial trust account.

22 (5) In conformance with Article II, section 37 of the state
23 Constitution, no treasury accounts or funds shall be allocated earnings
24 without the specific affirmative directive of this section.

25 **Sec. 37.** RCW 43.84.092 and 1999 c 380 s 9, 1999 c 309 s 929, 1999
26 c 268 s 5, and 1999 c 94 s 4 are each reenacted and amended to read as
27 follows:

28 (1) All earnings of investments of surplus balances in the state
29 treasury shall be deposited to the treasury income account, which
30 account is hereby established in the state treasury.

31 (2) The treasury income account shall be utilized to pay or receive
32 funds associated with federal programs as required by the federal cash
33 management improvement act of 1990. The treasury income account is
34 subject in all respects to chapter 43.88 RCW, but no appropriation is
35 required for refunds or allocations of interest earnings required by
36 the cash management improvement act. Refunds of interest to the
37 federal treasury required under the cash management improvement act
38 fall under RCW 43.88.180 and shall not require appropriation. The

1 office of financial management shall determine the amounts due to or
2 from the federal government pursuant to the cash management improvement
3 act. The office of financial management may direct transfers of funds
4 between accounts as deemed necessary to implement the provisions of the
5 cash management improvement act, and this subsection. Refunds or
6 allocations shall occur prior to the distributions of earnings set
7 forth in subsection (4) of this section.

8 (3) Except for the provisions of RCW 43.84.160, the treasury income
9 account may be utilized for the payment of purchased banking services
10 on behalf of treasury funds including, but not limited to, depository,
11 safekeeping, and disbursement functions for the state treasury and
12 affected state agencies. The treasury income account is subject in all
13 respects to chapter 43.88 RCW, but no appropriation is required for
14 payments to financial institutions. Payments shall occur prior to
15 distribution of earnings set forth in subsection (4) of this section.

16 (4) Monthly, the state treasurer shall distribute the earnings
17 credited to the treasury income account. The state treasurer shall
18 credit the general fund with all the earnings credited to the treasury
19 income account except:

20 (a) The following accounts and funds shall receive their
21 proportionate share of earnings based upon each account's and fund's
22 average daily balance for the period: The capitol building
23 construction account, the Cedar River channel construction and
24 operation account, the Central Washington University capital projects
25 account, the charitable, educational, penal and reformatory
26 institutions account, the common school construction fund, the county
27 criminal justice assistance account, the county sales and use tax
28 equalization account, the data processing building construction
29 account, the deferred compensation administrative account, the deferred
30 compensation principal account, the department of retirement systems
31 expense account, the drinking water assistance account, the Eastern
32 Washington University capital projects account, the education
33 construction fund, the emergency reserve fund, the federal forest
34 revolving account, the health services account, the public health
35 services account, the health system capacity account, the personal
36 health services account, the state higher education construction
37 account, the higher education construction account, the highway
38 infrastructure account, the industrial insurance premium refund
39 account, the judges' retirement account, the judicial retirement

1 administrative account, the judicial retirement principal account, the
2 local leasehold excise tax account, the local real estate excise tax
3 account, the local sales and use tax account, the medical aid account,
4 the mobile home park relocation fund, the municipal criminal justice
5 assistance account, the municipal sales and use tax equalization
6 account, the natural resources deposit account, the perpetual
7 surveillance and maintenance account, the public employees' retirement
8 system plan 1 account, the public employees' retirement system plan 2
9 account, the Puyallup tribal settlement account, the resource
10 management cost account, the site closure account, the special wildlife
11 account, the state employees' insurance account, the state employees'
12 insurance reserve account, the state investment board expense account,
13 the state investment board commingled trust fund accounts, the
14 supplemental pension account, the teachers' retirement system plan 1
15 account, the teachers' retirement system combined plan 2 and plan 3
16 account, the tobacco prevention and control account, the tobacco
17 settlement account, the transportation infrastructure account, the
18 tuition recovery trust fund, the University of Washington bond
19 retirement fund, the University of Washington building account, the
20 volunteer fire fighters' and reserve officers' relief and pension
21 principal ((~~account~~)) fund, the volunteer fire fighters' ((~~relief and~~
22 ~~pension~~)) and reserve officers' administrative ((~~account~~)) fund, the
23 Washington judicial retirement system account, the Washington law
24 enforcement officers' and fire fighters' system plan 1 retirement
25 account, the Washington law enforcement officers' and fire fighters'
26 system plan 2 retirement account, the Washington school employees'
27 retirement system combined plan 2 and 3 account, the Washington state
28 health insurance pool account, the Washington state patrol retirement
29 account, the Washington State University building account, the
30 Washington State University bond retirement fund, the water pollution
31 control revolving fund, and the Western Washington University capital
32 projects account. Earnings derived from investing balances of the
33 agricultural permanent fund, the normal school permanent fund, the
34 permanent common school fund, the scientific permanent fund, and the
35 state university permanent fund shall be allocated to their respective
36 beneficiary accounts. All earnings to be distributed under this
37 subsection (4)(a) shall first be reduced by the allocation to the state
38 treasurer's service fund pursuant to RCW 43.08.190.

1 (b) The following accounts and funds shall receive eighty percent
2 of their proportionate share of earnings based upon each account's or
3 fund's average daily balance for the period: The aeronautics account,
4 the aircraft search and rescue account, the county arterial
5 preservation account, the department of licensing services account, the
6 essential rail assistance account, the ferry bond retirement fund, the
7 grade crossing protective fund, the high capacity transportation
8 account, the highway bond retirement fund, the highway safety account,
9 the motor vehicle fund, the motorcycle safety education account, the
10 pilotage account, the public transportation systems account, the Puget
11 Sound capital construction account, the Puget Sound ferry operations
12 account, the recreational vehicle account, the rural arterial trust
13 account, the safety and education account, the special category C
14 account, the state patrol highway account, the transportation equipment
15 fund, the transportation fund, the transportation improvement account,
16 the transportation improvement board bond retirement account, and the
17 urban arterial trust account.

18 (5) In conformance with Article II, section 37 of the state
19 Constitution, no treasury accounts or funds shall be allocated earnings
20 without the specific affirmative directive of this section.

21 NEW SECTION. **Sec. 38.** A new section is added to chapter 48.01 RCW
22 to read as follows:

23 (1) Except as required in RCW 48.21.045, 48.44.023, and 48.46.066,
24 nothing in this title shall be construed to require a carrier, as
25 defined in RCW 48.43.005, to offer any health benefit plan for sale.

26 (2) Nothing in this title shall prohibit a carrier as defined in
27 RCW 48.43.005 from ceasing sale of any or all health benefit plans to
28 new applicants if the closed plans are closed to all new applicants.

29 (3) This section is intended to clarify, and not modify, existing
30 law.

31 NEW SECTION. **Sec. 39.** (1) The task force on health care
32 reinsurance is created, and is composed of seven members, including:
33 Three members appointed by the governor, one of whom shall be the chair
34 of the Washington state health insurance pool; two members of the
35 senate, one member of each party caucus appointed by the president of
36 the senate; and two members of the house of representatives, one member
37 of each party caucus appointed by the co-speakers of the house of

1 representatives. The chair shall be elected by the task force from
2 among its members.

3 (2) The task force shall:

4 (a) Monitor the provisions of this act regarding its effect on:

5 (i) Carrier participation in the individual market, especially in
6 areas where coverage is currently minimal;

7 (ii) Affordability and availability of private health plan
8 coverage;

9 (iii) Washington state health insurance pool operations; and

10 (iv) The Washington basic health plan operations;

11 (b) After studying the feasibility of reinsurance as a method of
12 health insurance market stability, develop a reinsurance system
13 implementation plan as appropriate; and

14 (c) Seek participation from interested parties, including but not
15 limited to consumer, carriers, health care providers, health care
16 purchasers, and insurance brokers and agents, in an effective manner.

17 (3) In the conduct of its business, the task force shall have
18 access to all health data available by statute to health-related state
19 agencies and may, to the extent that funds are available, purchase
20 necessary analytical and staff support.

21 (4) Task force members will receive no compensation for their
22 service.

23 (5) The task force shall submit an interim report to the governor
24 and the legislature in January 2001 and a final report no later than
25 December 1, 2001.

26 (6) The task force expires December 31, 2001.

27 **Sec. 40.** RCW 70.47.010 and 1993 c 492 s 208 are each amended to
28 read as follows:

29 (1)(a) The legislature finds that limitations on access to health
30 care services for enrollees in the state, such as in rural and
31 underserved areas, are particularly challenging for the basic health
32 plan. Statutory restrictions have reduced the options available to the
33 administrator to address the access needs of basic health plan
34 enrollees. It is the intent of the legislature to authorize the
35 administrator to develop alternative purchasing strategies to ensure
36 access to basic health plan enrollees in all areas of the state,
37 including: (i) The use of differential rating for managed health care
38 systems based on geographic differences in costs; and (ii) until

1 January 1, 2004, limited use of self-insurance in areas where adequate
2 access cannot be assured through other options.

3 (b) In developing alternative purchasing strategies to address
4 health care access needs, the administrator shall consult with
5 interested persons including health carriers, health care providers,
6 and health facilities, and with other appropriate state agencies
7 including the office of the insurance commissioner and the office of
8 community and rural health. In pursuing such alternatives, the
9 administrator shall continue to give priority to prepaid managed care
10 as the preferred method of assuring access to basic health plan
11 enrollees followed, in priority order, by preferred providers, fee for
12 service, and self-funding.

13 (2) The legislature further finds that:

14 (a) A significant percentage of the population of this state does
15 not have reasonably available insurance or other coverage of the costs
16 of necessary basic health care services;

17 (b) This lack of basic health care coverage is detrimental to the
18 health of the individuals lacking coverage and to the public welfare,
19 and results in substantial expenditures for emergency and remedial
20 health care, often at the expense of health care providers, health care
21 facilities, and all purchasers of health care, including the state; and

22 (c) The use of managed health care systems has significant
23 potential to reduce the growth of health care costs incurred by the
24 people of this state generally, and by low-income pregnant women, and
25 at-risk children and adolescents who need greater access to managed
26 health care.

27 ~~((+2))~~ (3) The purpose of this chapter is to provide or make more
28 readily available necessary basic health care services in an
29 appropriate setting to working persons and others who lack coverage, at
30 a cost to these persons that does not create barriers to the
31 utilization of necessary health care services. To that end, this
32 chapter establishes a program to be made available to those residents
33 not eligible for medicare who share in a portion of the cost or who pay
34 the full cost of receiving basic health care services from a managed
35 health care system.

36 ~~((+3))~~ (4) It is not the intent of this chapter to provide health
37 care services for those persons who are presently covered through
38 private employer-based health plans, nor to replace employer-based
39 health plans. However, the legislature recognizes that cost-effective

1 and affordable health plans may not always be available to small
2 business employers. Further, it is the intent of the legislature to
3 expand, wherever possible, the availability of private health care
4 coverage and to discourage the decline of employer-based coverage.

5 ~~((4))~~ (5)(a) It is the purpose of this chapter to acknowledge the
6 initial success of this program that has (i) assisted thousands of
7 families in their search for affordable health care; (ii) demonstrated
8 that low-income, uninsured families are willing to pay for their own
9 health care coverage to the extent of their ability to pay; and (iii)
10 proved that local health care providers are willing to enter into a
11 public-private partnership as a managed care system.

12 (b) As a consequence, the legislature intends to extend an option
13 to enroll to certain citizens above two hundred percent of the federal
14 poverty guidelines within the state who reside in communities where the
15 plan is operational and who collectively or individually wish to
16 exercise the opportunity to purchase health care coverage through the
17 basic health plan if the purchase is done at no cost to the state. It
18 is also the intent of the legislature to allow employers and other
19 financial sponsors to financially assist such individuals to purchase
20 health care through the program so long as such purchase does not
21 result in a lower standard of coverage for employees.

22 (c) The legislature intends that, to the extent of available funds,
23 the program be available throughout Washington state to subsidized and
24 nonsubsidized enrollees. It is also the intent of the legislature to
25 enroll subsidized enrollees first, to the maximum extent feasible.

26 (d) The legislature directs that the basic health plan
27 administrator identify enrollees who are likely to be eligible for
28 medical assistance and assist these individuals in applying for and
29 receiving medical assistance. The administrator and the department of
30 social and health services shall implement a seamless system to
31 coordinate eligibility determinations and benefit coverage for
32 enrollees of the basic health plan and medical assistance recipients.

33 **Sec. 41.** RCW 70.47.020 and 1997 c 335 s 1 are each amended to read
34 as follows:

35 As used in this chapter:

36 (1) "Washington basic health plan" or "plan" means the system of
37 enrollment and payment ~~((on a prepaid capitated basis))~~ for basic

1 health care services, administered by the plan administrator through
2 participating managed health care systems, created by this chapter.

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

6 (3) "Managed health care system" means: (a) Any health care
7 organization, including health care providers, insurers, health care
8 service contractors, health maintenance organizations, or any
9 combination thereof, that provides directly or by contract basic health
10 care services, as defined by the administrator and rendered by duly
11 licensed providers, ((on a prepaid capitated basis)) to a defined
12 patient population enrolled in the plan and in the managed health care
13 system; or (b) until January 1, 2004, a self-funded or self-insured
14 method of providing insurance coverage to subsidized enrollees provided
15 under RCW 41.05.140 and subject to the limitations under RCW
16 70.47.100(7).

17 (4) "Subsidized enrollee" means an individual, or an individual
18 plus the individual's spouse or dependent children: (a) Who is not
19 eligible for medicare; (b) who is not confined or residing in a
20 government-operated institution, unless he or she meets eligibility
21 criteria adopted by the administrator; (c) who resides in an area of
22 the state served by a managed health care system participating in the
23 plan; (d) whose gross family income at the time of enrollment does not
24 exceed twice the federal poverty level as adjusted for family size and
25 determined annually by the federal department of health and human
26 services; and (e) who chooses to obtain basic health care coverage from
27 a particular managed health care system in return for periodic payments
28 to the plan.

29 (5) "Nonsubsidized enrollee" means an individual, or an individual
30 plus the individual's spouse or dependent children: (a) Who is not
31 eligible for medicare; (b) who is not confined or residing in a
32 government-operated institution, unless he or she meets eligibility
33 criteria adopted by the administrator; (c) who resides in an area of
34 the state served by a managed health care system participating in the
35 plan; (d) who chooses to obtain basic health care coverage from a
36 particular managed health care system; and (e) who pays or on whose
37 behalf is paid the full costs for participation in the plan, without
38 any subsidy from the plan.

1 (6) "Subsidy" means the difference between the amount of periodic
2 payment the administrator makes to a managed health care system on
3 behalf of a subsidized enrollee plus the administrative cost to the
4 plan of providing the plan to that subsidized enrollee, and the amount
5 determined to be the subsidized enrollee's responsibility under RCW
6 70.47.060(2).

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

11 (8) "Rate" means the (~~per capita~~) amount, negotiated by the
12 administrator with and paid to a participating managed health care
13 system, that is based upon the enrollment of subsidized and
14 nonsubsidized enrollees in the plan and in that system.

15 **Sec. 42.** RCW 41.05.140 and 1994 c 153 s 10 are each amended to
16 read as follows:

17 (1) Except for property and casualty insurance, the authority may
18 self-fund, self-insure, or enter into other methods of providing
19 insurance coverage for insurance programs under its jurisdiction
20 ((except property and casualty insurance)), including the basic health
21 plan as provided in chapter 70.47 RCW. The authority shall contract
22 for payment of claims or other administrative services for programs
23 under its jurisdiction. If a program does not require the prepayment
24 of reserves, the authority shall establish such reserves within a
25 reasonable period of time for the payment of claims as are normally
26 required for that type of insurance under an insured program.

27 (2) Reserves established by the authority for employee and retiree
28 benefit programs shall be held in a separate trust fund by the state
29 treasurer and shall be known as the public employees' and retirees'
30 insurance reserve fund. The state investment board shall act as the
31 investor for the funds and, except as provided in RCW 43.33A.160, one
32 hundred percent of all earnings from these investments shall accrue
33 directly to the public employees' and retirees' insurance reserve fund.

34 (3) Any savings realized as a result of a program created for
35 employees and retirees under this section shall not be used to increase
36 benefits unless such use is authorized by statute.

37 (4) Reserves established by the authority to provide insurance
38 coverage for the basic health plan under chapter 70.47 RCW shall be

1 held in a separate trust account in the custody of the state treasurer
2 and shall be known as the basic health plan self-insurance reserve
3 account. The state investment board shall act as the investor for the
4 funds and, except as provided in RCW 43.33A.160, one hundred percent of
5 all earnings from these investments shall accrue directly to the basic
6 health plan self-insurance reserve account.

7 (5) Any program created under this section shall be subject to the
8 examination requirements of chapter 48.03 RCW as if the program were a
9 domestic insurer. In conducting an examination, the commissioner shall
10 determine the adequacy of the reserves established for the program.

11 ~~((+5))~~ (6) The authority shall keep full and adequate accounts and
12 records of the assets, obligations, transactions, and affairs of any
13 program created under this section.

14 ~~((+6))~~ (7) The authority shall file a quarterly statement of the
15 financial condition, transactions, and affairs of any program created
16 under this section in a form and manner prescribed by the insurance
17 commissioner. The statement shall contain information as required by
18 the commissioner for the type of insurance being offered under the
19 program. A copy of the annual statement shall be filed with the
20 speaker of the house of representatives and the president of the
21 senate.

22 **Sec. 43.** RCW 43.79A.040 and 1999 c 384 s 8 and 1999 c 182 s 2 are
23 each reenacted and amended to read as follows:

24 (1) Money in the treasurer's trust fund may be deposited, invested,
25 and reinvested by the state treasurer in accordance with RCW 43.84.080
26 in the same manner and to the same extent as if the money were in the
27 state treasury.

28 (2) All income received from investment of the treasurer's trust
29 fund shall be set aside in an account in the treasury trust fund to be
30 known as the investment income account.

31 (3) The investment income account may be utilized for the payment
32 of purchased banking services on behalf of treasurer's trust funds
33 including, but not limited to, depository, safekeeping, and
34 disbursement functions for the state treasurer or affected state
35 agencies. The investment income account is subject in all respects to
36 chapter 43.88 RCW, but no appropriation is required for payments to
37 financial institutions. Payments shall occur prior to distribution of
38 earnings set forth in subsection (4) of this section.

1 (4)(a) Monthly, the state treasurer shall distribute the earnings
2 credited to the investment income account to the state general fund
3 except under (b) and (c) of this subsection.

4 (b) The following accounts and funds shall receive their
5 proportionate share of earnings based upon each account's or fund's
6 average daily balance for the period: The Washington advanced college
7 tuition payment program account, the agricultural local fund, the
8 American Indian scholarship endowment fund, the basic health plan self-
9 insurance reserve account, the Washington international exchange
10 scholarship endowment fund, the developmental disabilities endowment
11 trust fund, the energy account, the fair fund, the game farm
12 alternative account, the grain inspection revolving fund, the juvenile
13 accountability incentive account, the rural rehabilitation account, the
14 stadium and exhibition center account, the youth athletic facility
15 grant account, the self-insurance revolving fund, the sulfur dioxide
16 abatement account, and the children's trust fund. However, the
17 earnings to be distributed shall first be reduced by the allocation to
18 the state treasurer's service fund pursuant to RCW 43.08.190.

19 (c) The following accounts and funds shall receive eighty percent
20 of their proportionate share of earnings based upon each account's or
21 fund's average daily balance for the period: The advanced right of way
22 revolving fund, the advanced environmental mitigation revolving
23 account, the federal narcotics asset forfeitures account, the high
24 occupancy vehicle account, the local rail service assistance account,
25 and the miscellaneous transportation programs account.

26 (5) In conformance with Article II, section 37 of the state
27 Constitution, no trust accounts or funds shall be allocated earnings
28 without the specific affirmative directive of this section.

29 NEW SECTION. **Sec. 44.** (1) The sum of seventy-five thousand
30 dollars, or as much thereof as may be necessary, is appropriated for
31 the fiscal year ending June 30, 2000, from the general fund to the
32 office of financial management for the task force on health care
33 reinsurance created in section 39 of this act.

34 (2) The sum of fifty thousand dollars, or as much thereof as may be
35 necessary, is appropriated for the fiscal year ending June 30, 2001,
36 from the general fund to the office of financial management for the
37 task force on health care reinsurance created in section 39 of this
38 act.

1 NEW SECTION. **Sec. 45.** RCW 48.41.180 (Offer of coverage to
2 eligible persons) and 1987 c 431 s 18 are each repealed.

3 NEW SECTION. **Sec. 46.** If any provision of this act or its
4 application to any person or circumstance is held invalid, the
5 remainder of the act or the application of the provision to other
6 persons or circumstances is not affected.

7 NEW SECTION. **Sec. 47.** Sections 35 and 36 of this act expire
8 September 1, 2000.

9 NEW SECTION. **Sec. 48.** (1) Section 36 of this act takes effect
10 July 1, 2000.

11 (2) Section 37 of this act takes effect September 1, 2000.

12 NEW SECTION. **Sec. 49.** Except for sections 36 and 37 of this act,
13 this act is necessary for the immediate preservation of the public
14 peace, health, or safety, or support of the state government and its
15 existing public institutions, and takes effect immediately."

16 **2SSB 6067** - S AMD - 100
17 By Senator Deccio

18 PULLED 2/29/00

19 On page 1, line 1 of the title, after "coverage;" strike the
20 remainder of the title and insert "amending RCW 48.04.010, 48.18.110,
21 48.20.028, 48.41.020, 48.41.030, 48.41.060, 48.41.080, 48.41.090,
22 48.41.100, 48.41.110, 48.41.120, 48.41.130, 48.41.140, 48.41.200,
23 48.43.015, 48.43.025, 48.43.035, 48.44.020, 48.44.022, 48.46.060,
24 48.46.064, 70.47.100, 70.47.010, 70.47.020, and 41.05.140; reenacting
25 and amending RCW 48.43.005, 70.47.060, 43.84.092, 43.84.092, 43.84.092,
26 and 43.79A.040; adding a new section to chapter 48.20 RCW; adding new
27 sections to chapter 48.41 RCW; adding new sections to chapter 48.43
28 RCW; adding new sections to chapter 48.46 RCW; adding a new section to
29 chapter 48.44 RCW; adding a new section to chapter 48.01 RCW; creating
30 a new section; repealing RCW 48.41.180; making appropriations;

1 providing effective dates; providing an expiration date; and declaring
2 an emergency."

--- END ---