

2SSB 5930 - S AMD TO S AMD (S-2717.2/07)  
By Senator Pflug

1 On page 13, line 30 of the amendment, after "19." strike all  
2 material through "section" on page 15, line 24 of the amendment and  
3 insert "The legislature finds that:

4 (1) The people of Washington have expressed strong concerns about  
5 health care costs and access to needed health services. Even if  
6 currently insured, they are not confident that they will continue to  
7 have health insurance coverage in the future and feel that they are  
8 getting less, but spending more.

9 (2) Many employers, especially small employers, struggle with the  
10 cost of providing employer-sponsored health insurance coverage to their  
11 employees, while others are unable to offer employer-sponsored health  
12 insurance due to its high cost. In addition, small employers continue  
13 to invest a significant amount of their time in the health insurance  
14 business as they are the lone gateway to group coverage for their  
15 employees. This is time better served meeting their customers' needs  
16 and fulfilling the many demands and challenges of our ever-changing  
17 marketplace. Even after much research has been done by the employer to  
18 secure a health benefit plan that works for everyone, it is, too often,  
19 that some individuals are forced into a choice of health care coverage  
20 they would have never made on their own, if given that chance.

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

28 (4) Lack of portability remains a constant problem as thousands of  
29 Washington residents go uninsured every year simply because they are  
30 temporarily between jobs or their new job does not offer an affordable  
31 option for them. In addition, two-income earner families are punished  
32 by the system as they are forced to choose one employer's health

1 insurance plan over another without a chance to collect premium  
2 contributions from both.

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

16 (6) There are very few incentives for young adults, nineteen  
17 through thirty years old, to purchase their own health coverage.  
18 Young, healthy adults are often quoted rates that are incongruent with  
19 their level of risk and do not make financial sense when they look at  
20 the cost benefit ratio. By failing to offer the right incentives for  
21 this population to enroll in a health insurance plan, we have created  
22 layers of problems such as increased uncompensated care and less  
23 preventative care being sought.

24 NEW SECTION. **Sec. 20.** The legislature intends, through the  
25 public/private partnership reflected in this act, to improve our  
26 current health care system so that:

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

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

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

33 (4) Administrative costs at every level are reduced;

34 (5) As a result of these changes, more people in Washington state  
35 have access to affordable health insurance coverage and health outcomes  
36 in Washington state are improved; and

37 (6) More insurance coverage choices are available to all health  
38 consumers.

1  
2 NEW SECTION. **Sec. 21.**

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

7 (3) "Commissioner" means the insurance commissioner established  
8 under RCW 48.02.010.

9 (4) "Eligible individual" means an individual who is eligible to  
10 participate in the exchange by reason of meeting one or more of the  
11 following qualifications:

12 (a) The individual is a Washington resident, meaning that the  
13 individual is, and continues to be, residing on a permanent and  
14 full-time basis in a place of permanent habitation in Washington that  
15 remains the person's principal residence and from which the person is  
16 absent only for temporary or transitory purposes. A person who is a  
17 full-time student attending an institution outside of Washington may  
18 maintain his or her Washington residency;

19 (b) The individual is not a Washington resident but is employed, at  
20 least twenty hours a week on a regular basis, at a Washington location  
21 by a bona fide employer, and the individual's employer does not offer  
22 a group health insurance plan, or the individual is not eligible to  
23 participate in any group health insurance plan offered by the  
24 individual's employer;

25 (c) The individual, whether a resident or not, is enrolled in, or  
26 eligible to enroll in, a participating employer plan;

27 (d) The individual is self-employed in Washington, and if a  
28 nonresident self-employed individual, the individual's principal place  
29 of business is in Washington;

30 (e) The individual is a full-time student attending an institution  
31 of higher education located in Washington;

32 (f) The individual, whether a resident or not, is a dependent of  
33 another individual who is an eligible individual;

34 (g) The individual is eligible for benefits under section 210 of  
35 the federal trade act of 2002, at 26 U.S.C. Sec. 35(c).

36 (5) "Eligible employer" means any individual, partnership,  
37 association, corporation, business trust, or person or group of persons  
38 employing one or more persons, and filing payroll tax information on  
39 each person.

1 (6) "Executive director" means an individual appointed by a vote of  
2 the exchange board to serve as the secretary of administration and  
3 finance for the exchange board.

4 (7) "Exchange" means the Washington state health insurance exchange  
5 established in section 203 of this act.

6 (8) "Exchange board" and "board" means the board of the Washington  
7 state health insurance exchange established in section 204 of this act.

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

10 (10) "Participating individual" means a person who has been  
11 determined by the exchange to be, and continues to be, an eligible  
12 individual or an employee of a participating employer plan for purposes  
13 of obtaining coverage through the exchange.

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

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

22 (13) "Premium assistance payment" means a payment made to carriers  
23 by the exchange as provided in section 208 of this act.

24 **Sec. 22.** RCW 41.05.021 and 2006 c 103 s 2 are each amended to read  
25 as follows:

26 ((~~(1)~~)) The Washington state health care authority is created  
27 within the executive branch. The authority shall have an administrator  
28 appointed by the governor, with the consent of the senate. The  
29 administrator shall serve at the pleasure of the governor. The  
30 administrator may employ up to seven staff members, who shall be exempt  
31 from chapter 41.06 RCW, and any additional staff members as are  
32 necessary to administer this chapter. The administrator may delegate  
33 any power or duty vested in him or her by this chapter, including  
34 authority to make final decisions and enter final orders in hearings  
35 conducted under chapter 34.05 RCW. The primary duties of the authority  
36 shall be to: Administer state employees' insurance benefits and  
37 retired or disabled school employees' insurance benefits; administer  
38 the basic health plan pursuant to chapter 70.47 RCW; study state-

1 purchased health care programs in order to maximize cost containment in  
2 these programs while ensuring access to quality health care; and  
3 implement state initiatives, joint purchasing strategies, and  
4 techniques for efficient administration that have potential application  
5 to all state-purchased health services. The authority's duties  
6 include, but are not limited to, the following:

7 ~~((a))~~ (1) To administer health care benefit programs for  
8 employees and retired or disabled school employees as specifically  
9 authorized in RCW 41.05.065 and in accordance with the methods  
10 described in RCW 41.05.075, 41.05.140, and other provisions of this  
11 chapter;

12 ~~((b))~~ (2) To analyze state-purchased health care programs and to  
13 explore options for cost containment and delivery alternatives for  
14 those programs that are consistent with the purposes of those programs,  
15 including, but not limited to:

16 ~~((i))~~ (a) Creation of economic incentives for the persons for  
17 whom the state purchases health care to appropriately utilize and  
18 purchase health care services, including the development of flexible  
19 benefit plans to offset increases in individual financial  
20 responsibility;

21 ~~((ii))~~ (b) Utilization of provider arrangements that encourage  
22 cost containment, including but not limited to prepaid delivery  
23 systems, utilization review, and prospective payment methods, and that  
24 ensure access to quality care, including assuring reasonable access to  
25 local providers, especially for employees residing in rural areas;

26 ~~((iii))~~ (c) Coordination of state agency efforts to purchase  
27 drugs effectively as provided in RCW 70.14.050;

28 ~~((iv))~~ (d) Development of recommendations and methods for  
29 purchasing medical equipment and supporting services on a volume  
30 discount basis;

31 ~~((v))~~ (e) Development of data systems to obtain utilization data  
32 from state-purchased health care programs in order to identify cost  
33 centers, utilization patterns, provider and hospital practice patterns,  
34 and procedure costs, utilizing the information obtained pursuant to RCW  
35 41.05.031; and

36 ~~((vi))~~ (f) In collaboration with other state agencies that  
37 administer state purchased health care programs, private health care  
38 purchasers, health care facilities, providers, and carriers:

1        ~~((A))~~ (i) Use evidence-based medicine principles to develop  
2 common performance measures and implement financial incentives in  
3 contracts with insuring entities, health care facilities, and providers  
4 that:

5        ~~((I))~~ (A) Reward improvements in health outcomes for individuals  
6 with chronic diseases, increased utilization of appropriate preventive  
7 health services, and reductions in medical errors; and

8        ~~((II))~~ (B) Increase, through appropriate incentives to insuring  
9 entities, health care facilities, and providers, the adoption and use  
10 of information technology that contributes to improved health outcomes,  
11 better coordination of care, and decreased medical errors;

12       ~~((B))~~ (ii) Through state health purchasing, reimbursement, or  
13 pilot strategies, promote and increase the adoption of health  
14 information technology systems, including electronic medical records,  
15 by hospitals as defined in RCW 70.41.020(4), integrated delivery  
16 systems, and providers that:

17       ~~((I))~~ (A) Facilitate diagnosis or treatment;

18       ~~((II))~~ (B) Reduce unnecessary duplication of medical tests;

19       ~~((III))~~ (C) Promote efficient electronic physician order entry;

20       ~~((IV))~~ (D) Increase access to health information for consumers  
21 and their providers; and

22       ~~((V))~~ (E) Improve health outcomes;

23       ~~((C))~~ (iii) Coordinate a strategy for the adoption of health  
24 information technology systems using the final health information  
25 technology report and recommendations developed under chapter 261, Laws  
26 of 2005~~((-))~~;

27       ~~((c))~~ (3) To analyze areas of public and private health care  
28 interaction;

29       ~~((d))~~ (4) To provide information and technical and administrative  
30 assistance to the board;

31       ~~((e))~~ (5) To review and approve or deny applications from  
32 counties, municipalities, and other political subdivisions of the state  
33 to provide state-sponsored insurance or self-insurance programs to  
34 their employees in accordance with the provisions of RCW 41.04.205,  
35 setting the premium contribution for approved groups as outlined in RCW  
36 41.05.050;

37       ~~((f))~~ (6) To establish billing procedures and collect funds from  
38 school districts in a way that minimizes the administrative burden on  
39 districts;

1       ~~((g))~~ (7) To publish and distribute to nonparticipating school  
2 districts and educational service districts by October 1st of each year  
3 a description of health care benefit plans available through the  
4 authority and the estimated cost if school districts and educational  
5 service district employees were enrolled;

6       ~~((h))~~ (8) To facilitate and cooperate with the Washington state  
7 health insurance exchange established in section 203 of this act as  
8 follows:

9       (a) Establish, if the exchange board finds it necessary, a risk  
10 adjustment mechanism for premiums paid to carriers;

11       (b) Establish and manage a system for determining eligibility for  
12 premium assistance payments and remitting premium assistance payments  
13 to the carriers in accordance with the health insurance exchange;

14       (9) To apply for, receive, and accept grants, gifts, and other  
15 payments, including property and service, from any governmental or  
16 other public or private entity or person, and make arrangements as to  
17 the use of these receipts to implement initiatives and strategies  
18 developed under this section; and

19       ~~((i))~~ (10) To promulgate and adopt rules consistent with this  
20 chapter as described in RCW 41.05.160.

21       ~~((2) On and after January 1, 1996, the public employees' benefits~~  
22 ~~board may implement strategies to promote managed competition among~~  
23 ~~employee health benefit plans. Strategies may include but are not~~  
24 ~~limited to:~~

25       ~~— (a) Standardizing the benefit package;~~

26       ~~— (b) Soliciting competitive bids for the benefit package;~~

27       ~~— (c) Limiting the state's contribution to a percent of the lowest~~  
28 ~~priced qualified plan within a geographical area;~~

29       ~~— (d) Monitoring the impact of the approach under this subsection~~  
30 ~~with regards to: Efficiencies in health service delivery, cost shifts~~  
31 ~~to subscribers, access to and choice of managed care plans statewide,~~  
32 ~~and quality of health services. The health care authority shall also~~  
33 ~~advise on the value of administering a benchmark employer-managed plan~~  
34 ~~to promote competition among managed care plans.))~~

35       NEW SECTION. Sec. 23. (1) There is hereby established by the state  
36 of Washington the Washington state health insurance exchange as a body  
37 corporate and an independent instrumentality of the state of

1 Washington, created to serve public purposes provided for in this act,  
2 but with legal existence separate from that of the state of Washington.

3 (2) The exchange is hereby recognized as a not-for-profit  
4 corporation in accordance with the provisions of Title 24 RCW, and  
5 shall seek recognition of the same status by the United States in  
6 accordance with the provisions of the United States internal revenue  
7 code, 26 U.S.C. Sec. 501(c).

8 (3) The limited purpose of the exchange is to facilitate the  
9 availability, portability, choice, and adoption of private health  
10 insurance plans to eligible individuals and groups, as provided in this  
11 chapter.

12 (4) The exchange shall be administered by the executive director  
13 and governed by the Washington state health insurance exchange board  
14 established in section 204 of this act.

15 (5) The board shall appoint an executive director to serve as the  
16 secretary of administration and finance for the exchange and shall  
17 grant him or her the following powers and duties:

18 (a) Plan, direct, coordinate, and execute administrative functions  
19 in conformity with the policies and directives of the board;

20 (b) Employ professional and clerical staff as necessary;

21 (c) Report to the board on all operations under his or her control  
22 and supervision;

23 (d) Prepare an annual budget and manage the administrative expenses  
24 of the exchange; and

25 (e) Undertake any other activities necessary to implement the  
26 powers and duties set forth in this chapter.

27 NEW SECTION. **Sec. 24.** (1) The Washington state health insurance  
28 exchange board is hereby established. The function of the board is to  
29 develop and approve rules necessary for operation of the Washington  
30 state health insurance exchange.

31 (2) The exchange board shall be composed of thirteen voting members  
32 initially appointed by the governor as follows:

33 (a) A health economist;

34 (b) One representative of small businesses;

35 (c) One employee health plan benefits specialist;

36 (d) One representative of health care consumers;

37 (e) A physician licensed in good standing under chapter 18.57 RCW;



1 (f) A health insurance broker licensed in good standing under  
2 chapter 48.17 RCW;

3 (g) A representative of organized labor;

4 (h) A representative of business associations;

5 (i) A representative from the association of Washington health care  
6 plans;

7 (j) The assistant secretary of the department of social and health  
8 services, health recovery services administration, ex officio;

9 (k) The insurance commissioner, ex officio;

10 (l) The administrator of the health care authority, ex officio; and

11 (m) The executive director, ex officio.

12 (3) The governor shall appoint the initial members of the board to  
13 staggered terms not to exceed four years. Members appointed or elected  
14 thereafter shall serve two-year terms. Members of the board shall be  
15 compensated in accordance with RCW 43.03.250 and shall be reimbursed  
16 for their travel expenses while on official business in accordance with  
17 RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the  
18 conduct of its business. The executive director shall serve as chair  
19 of the board. Meetings of the board shall be at the call of the chair.

20 (4) The board may establish technical advisory committees or seek  
21 the advice of technical experts when necessary to execute the powers  
22 and duties included in section 205 of this act.

23 (5) Upon the end of each corresponding term of service for such  
24 positions as are to be prescribed, the board shall provide rules and  
25 guidelines, such as they are necessary, for the nomination and  
26 selection of industry representatives by their peers for the following  
27 seven board positions:

28 (a) One representative of small businesses;

29 (b) One employee health plan specialist;

30 (c) One representative of health care consumers;

31 (d) A physician licensed in good standing under chapter 18.57 RCW;

32 (e) A health insurance broker licensed in good standing under  
33 chapter 48.17 RCW;

34 (f) A representative of organized labor; and

35 (g) A representative of trade associations.

36 NEW SECTION. **Sec. 25.** The exchange board has the following duties  
37 and powers:

1 (1) Establish procedures for the enrollment of eligible individuals  
2 and groups, including:

3 (a) Publicizing the existence of the exchange and disseminating  
4 information on eligibility requirements and enrollment procedures for  
5 the exchange;

6 (b) Establishing procedures to determine each applicant's  
7 eligibility for purchasing insurance offered by the exchange, including  
8 a standard application form for eligible individuals and groups seeking  
9 to purchase health insurance through the exchange, as well as persons  
10 seeking a premium assistance payment. The application shall include  
11 information necessary to determine an applicant's eligibility, previous  
12 health insurance coverage history, and payment method;

13 (c) Establishing rules related to minimum participation of  
14 employees in groups seeking to purchase health insurance through the  
15 exchange;

16 (d) Preparing and distributing certificate of eligibility forms and  
17 application forms to insurance brokers and the general public; and

18 (e) Establishing and administering procedures for the election of  
19 coverage by participating individuals during open enrollment periods  
20 and outside of open enrollment periods upon the occurrence of any  
21 qualifying event specified in the federal health insurance portability  
22 and accountability act of 1996 or applicable state law. The procedures  
23 shall include preparing and distributing to participating individuals:

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

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

28 (2) Establish and manage a system of collecting and transmitting to  
29 the applicable carriers all premium payments or contributions made by  
30 or on behalf of participating individuals, including developing  
31 mechanisms to receive and process automatic payroll deductions for  
32 participating individuals enrolled in employer plans;

33 (3) Establish a plan for operating a health insurance service  
34 center to provide eligible individuals and employers with information  
35 on the exchange and manage exchange enrollment, and for publicizing the  
36 existence of the exchange and the exchange's eligibility requirements  
37 and enrollment procedures;

38 (4) Establish other procedures for operations of the exchange,  
39 including but not limited to procedures to:

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

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

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

7 (d) Charge and equitably apportion among participating institutions  
8 its administrative costs and expenses incurred in the exercise of the  
9 powers and duties granted by this chapter;

10 (e) Adopt bylaws for the regulation of its affairs and the conduct  
11 of its business;

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

13 (g) Establish lines of credit, and establish one or more cash and  
14 investment accounts to receive payments for services rendered and  
15 appropriations from the state, and for all other business activity  
16 granted by this chapter except to the extent otherwise limited by any  
17 applicable provision of the employee retirement income security act of  
18 1974; and

19 (h) Enter into interdepartmental agreements with the office of the  
20 insurance commissioner, department of social and health services,  
21 health care authority, and any other state agencies the board deems  
22 necessary to implement this chapter; and

23 (5) Begin offering access to health benefit plans under this act on  
24 September 1, 2008.

25 NEW SECTION. **Sec. 26.** ENROLLMENT AND COVERAGE ELECTION. Any  
26 eligible individual may apply to participate in the exchange. An  
27 employer, a labor union, or an educational, professional, civic, trade,  
28 church, or social organization that has eligible individuals as  
29 employees or members may apply on behalf of those eligible persons.  
30 Upon determination by the exchange that an individual is eligible to  
31 participate in the exchange, he or she may enroll in a health plan  
32 offered through the exchange during the next open enrollment period or,  
33 outside of open enrollment periods, upon the occurrence of any  
34 qualifying event specified in the federal health insurance portability  
35 and accountability act of 1996 or applicable state law. The initial  
36 open enrollment period is September 1, 2008, through November 30, 2008.

1        NEW SECTION.    **Sec. 27.**    PARTICIPATING EMPLOYER PLANS.    (1) Any  
2 employer may apply to the exchange to be the sponsor of a participating  
3 employer plan.

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

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

12        (b) Any individual eligible to participate in the exchange by  
13 reason of his or her eligibility for coverage under the employer's  
14 participating employer plan, regardless of whether any such individual  
15 would otherwise qualify as an eligible individual if not enrolled in  
16 the participating employer plan, may elect coverage under any health  
17 plan offered through the exchange, and neither the employer nor the  
18 exchange shall limit such individual's choice of coverage from among  
19 all the health plans offered;

20        (c) The employer agrees that, for the term of the agreement, the  
21 employer will not offer to individuals eligible to participate in the  
22 exchange by reason of their eligibility for coverage under the  
23 employer's participating employer plan any separate or competing health  
24 plan, regardless of whether any such individuals would otherwise  
25 qualify as eligible individuals if not enrolled in the participating  
26 employer plan;

27        (d) The employer reserves the right to offer benefits supplemental  
28 to the benefits offered through the exchange, but any supplemental  
29 benefits offered by the employer shall constitute a separate plan or  
30 plans under federal law, for which the executive director shall not be  
31 the plan administrator and for which neither the executive director nor  
32 the exchange shall be responsible in any manner;

33        (e) The employer reserves the right to determine the criteria for  
34 eligibility and enrollment in the participating employer plan and the  
35 terms and amounts of the employer's contributions to that plan, so long  
36 as for the term of the agreement with the exchange the employer agrees  
37 not to alter or amend any criteria or contribution amounts at any time  
38 other than during an annual period designated by the exchange for

1 participating employer plans to make such changes in conjunction with  
2 the exchange's annual open enrollment period;

3 (f) The employer agrees to make available to the exchange any of  
4 the employer's documents, records, or information, including copies of  
5 the employer's federal and state tax and wage reports, that the  
6 executive director reasonably determines are necessary for the exchange  
7 to verify:

8 (i) That the employer is in compliance with the terms of its  
9 agreement with the exchange governing the employer's sponsorship of a  
10 participating employer plan;

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

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

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

19 (3) Beginning on January 1, 2009, the state of Washington shall  
20 enter into an agreement with the exchange to be the sponsor of a  
21 participating employer plan on behalf of all individuals eligible for  
22 health insurance benefits paid in whole or in part by the state of  
23 Washington by reason of current or past employment by the state, or by  
24 reason of being a dependent of such an individual, except for any  
25 individuals who are eligible only for benefits consisting solely of  
26 coverage of expected benefits.

27 NEW SECTION. **Sec. 28.** EXCHANGE PREMIUM ASSISTANCE PROGRAM. (1)

28 The exchange shall provide the basic and underlying administrative  
29 functions for the premium assistance program established in this  
30 section and remit premium assistance payments to carriers offering  
31 health plans through the exchange. All eligibility, regulatory, and  
32 programmatic decisions shall be made by the health care authority, and  
33 such information shall be shared with the exchange board as deemed  
34 necessary.

35 (2) Beginning January 1, 2009, the administrator of the health care  
36 authority shall accept applications for premium assistance from  
37 eligible individuals and employees of participating employer plans who  
38 have family income up to two hundred percent of the federal poverty

1 level, as determined annually by the federal department of health and  
2 human services, on behalf of themselves, their spouses, and their  
3 dependent children.

4 (3) The health care authority shall design and implement a schedule  
5 of premium assistance payments that is based upon gross family income,  
6 giving appropriate consideration to family size and the ages of all  
7 family members. The benchmark plan for purposes of designing the  
8 premium assistance payment schedule shall be in conformity with the  
9 average quality of benefits covered in the top three subscribed plans  
10 in the individual insurance market as of January 1, 2007. After  
11 January 1, 2009, the benchmark plan for purposes of the premium  
12 assistance payment schedule shall be adjusted in conformity with the  
13 top three subscribed plans in the exchange.

14 The premium assistance schedule shall be applied to eligible  
15 individuals, and to the employee premium obligation remaining after  
16 employer premium contributions for employees of participating employer  
17 plans, so that employees benefit financially from their employers'  
18 contribution to the cost of their coverage through the exchange. Any  
19 surcharge included in the premium under section 211 of this act shall  
20 be included when determining the appropriate level of premium  
21 assistance payments.

22 (4) A financial sponsor may, with the prior approval of the  
23 executive director, pay the premium or any other amount on behalf of an  
24 eligible individual or employee of a participating employer plan, by  
25 arrangement with the individual or employee and through a mechanism  
26 acceptable to the executive director. The executive director shall  
27 establish a mechanism for receiving premium payments from the United  
28 States internal revenue service for eligible individuals who are  
29 eligible for benefits under section 210 of the federal trade act of  
30 2002, at 26 U.S.C. Sec. 35(c).

31 (5) The exchange shall remit the premium assistance in an amount  
32 determined under subsection (3) of this section to the carrier offering  
33 the health plan in which the eligible individual or employee of a  
34 participating employer plan has chosen to enroll. If, however, such  
35 individual or employee has chosen to enroll in a high deductible health  
36 plan, any difference between the amount of premium assistance that the  
37 individual or employee would receive and the applicable premium rate  
38 for the high deductible health plan shall be deposited into a health  
39 savings account for the benefit of that individual or employee.

1 (6) As of January 1, 2009, all basic health plan enrollees under  
2 chapter 70.47 RCW shall transition to the premium assistance program.  
3 The health care authority shall provide information and assistance  
4 necessary to allow enrollees to successfully transition to the premium  
5 assistance program, including assistance with enrolling in the exchange  
6 and choosing a health plan during the 2008 open enrollment period.

7 NEW SECTION. **Sec. 29.** EXCHANGE PREMIUM ASSISTANCE ACCOUNT. The  
8 exchange premium assistance account is hereby established in the  
9 custody of the state treasurer. Any nongeneral fund--state funds  
10 collected for the exchange premium assistance program shall be  
11 deposited in the exchange premium assistance account. Moneys in the  
12 account shall be used exclusively for the purposes of administering the  
13 exchange premium assistance account, including payments to carriers on  
14 behalf of eligible individuals and employees of participating employer  
15 plans. Only the executive director may authorize expenditures from the  
16 account. The account is subject to allotment procedures under chapter  
17 43.88 RCW, but an appropriation is not required for expenditures.

18 NEW SECTION. **Sec. 30.** BROKER COMMISSIONS. (1) When an eligible  
19 individual or eligible group is enrolled in the exchange by a health  
20 insurance broker or solicitor licensed under chapter 48.17 RCW, the  
21 exchange shall pay the broker a commission determined by the exchange  
22 board. In setting the commission, the exchange board shall consider  
23 rates of commissions paid to brokers for health plans issued under  
24 chapters 48.21, 48.44, and 48.46 RCW as of January 1, 2007.

25 (2) In cases where a membership organization enrolls in the  
26 exchange its eligible members, or the eligible members of its member  
27 entities, the plan chosen by each individual shall pay the organization  
28 a fee equal to the commission specified in subsection (1) of this  
29 section. Nothing in this section shall be deemed either to require a  
30 membership organization that enrolls persons in the exchange to be  
31 licensed by Washington as an insurance broker, or to permit such an  
32 organization to provide any other services requiring licensure as an  
33 insurance broker without first obtaining such license.

34 NEW SECTION. **Sec. 31.** SURCHARGE FOR EXCHANGE EXPENSES. (1) The  
35 exchange is authorized to apply a surcharge to all health benefit  
36 plans, which shall be used only to pay for administrative and

1 operational expenses of the exchange. Such a surcharge shall be  
2 applied uniformly to all health benefit plans offered through the  
3 exchange and shall be included in the premium for each health plan. As  
4 part of the premium, the surcharge shall be subject to the premium tax  
5 under RCW 48.14.020. These surcharges shall not be used to pay any  
6 premium assistance payments under this chapter.

7 (2) Each carrier participating in the exchange shall be required to  
8 furnish such reasonable reports as the board determines necessary to  
9 enable the executive director to carry out his or her duties under this  
10 chapter.

11 NEW SECTION. **Sec. 32.** FINANCIAL REPORT. The exchange shall keep  
12 an accurate account of all its activities and of all its receipts and  
13 expenditures and shall annually make a report as of the end of its  
14 fiscal year to its board, to the governor, and to the legislature, such  
15 reports to be in a form prescribed by the board. The board may  
16 investigate the affairs of the exchange, may severally examine the  
17 properties and records of the exchange, and may prescribe methods of  
18 accounting and the rendering of periodical reports in relation to  
19 projects undertaken by the exchange. The exchange shall be subject to  
20 biennial audit by the state auditor.

21 NEW SECTION. **Sec. 33.** REPORTS. No later than two years after the  
22 exchange begins operation and every year thereafter, the exchange shall  
23 conduct a study of the exchange and the persons enrolled in the  
24 exchange and shall submit a written report to the governor and the  
25 legislature on the status and activities of the exchange based on data  
26 collected in the study. The report shall also be available to the  
27 general public. The study shall review:

28 (1) The operation and administration of the exchange, including  
29 surveys and reports of health benefit plans available to participating  
30 individuals and on the experience of the plans. The experience on the  
31 plans shall include data on enrollees in the exchange, the operation  
32 and administration of the exchange premium assistance program,  
33 expenses, claims statistics, complaints data, how the exchange met its  
34 goals, and other information deemed pertinent by the exchange; and

35 (2) Any significant observations regarding utilization and adoption  
36 of the exchange.



1           NEW SECTION.   **Sec. 34.**   REPORT ON MEDICAID AND STATE CHILDREN'S  
2 HEALTH INSURANCE PROGRAM ENROLLEE PARTICIPATION IN THE EXCHANGE.   On or  
3 before September 1, 2010, the Washington state institute for public  
4 policy in cooperation with the exchange board shall prepare a report  
5 and shall make recommendations regarding the participation of  
6 categorically needy medicaid and state children's health insurance  
7 program enrollees in the exchange.   The report shall be submitted to  
8 the governor, the secretary of the department of social and health  
9 services, and relevant committees of the legislature.   The report shall  
10 examine the following issues:

11           (1) The impact of medicaid and state children's health insurance  
12 program enrollees participating in the exchange, with respect to the  
13 utilization of services and cost of health plans offered through the  
14 exchange;

15           (2) Whether any distinction should be made between adult and child  
16 enrollees;

17           (3) Opportunities to provide plan design flexibility through  
18 medicaid state plan amendments;

19           (4) The need for a new section 1115 waiver from the federal  
20 government for moving a sizable portion of the medicaid and state  
21 children's health insurance program population into a defined  
22 contribution model;

23           (5) A study of other states that have attempted similar reforms  
24 involving a defined contribution model within their medicaid population  
25 and whether any ideas should be incorporated to facilitate the move of  
26 enrollees to the exchange;

27           (6) Whether any cost savings to the state would result from the  
28 incorporation of medicaid and state children's health insurance program  
29 enrollees to the exchange;

30           (7) The effect any such move would have on the premiums of current  
31 exchange enrollees;

32           (8) The capacity of participating carriers in the exchange to  
33 properly manage the care of medicaid and state children's health  
34 insurance program enrollees;

35           (9) The impact of expanded choice and cost sharing on medicaid  
36 enrollees;

37           (10) What specific categories of categorically needy medicaid and  
38 state children's health insurance program enrollees, if any, should be  
39 excluded from participation in the exchange; and

1 (11) If the board recommends participation of any medicaid eligible  
2 citizens in the exchange, how the composition of the board should be  
3 modified to reflect their participation.

4 NEW SECTION. **Sec. 35.** RULES. The executive director may adopt  
5 any rules necessary to implement this chapter.

6 **Sec. 36.** RCW 48.43.005 and 2006 c 25 s 16 are each amended to read  
7 as follows:

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

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

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

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

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

22 (5) "Catastrophic health plan" means:

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

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

35 (c) Any health benefit plan that provides benefits for hospital  
36 inpatient and outpatient services, professional and prescription drugs  
37 provided in conjunction with such hospital inpatient and outpatient

1 services, and excludes or substantially limits outpatient physician  
2 services and those services usually provided in an office setting.

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

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

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

15 (9) "Creditable coverage" means continual coverage of the applicant  
16 under any of the following health plans, with no lapse in coverage of  
17 more than sixty-three days immediately prior to the date of  
18 application:

19 (a) A group health plan;

20 (b) Health insurance coverage;

21 (c) Part A or Part B of Title XVIII of the social security act,  
22 approved July 30, 1965 (79 Stat. 291; 42 U.S.C. Sec. 1395c et seq. or  
23 1395j et seq., respectively);

24 (d) Title XIX of the social security act, approved July 30, 1965  
25 (79 Stat. 343; 42 U.S.C. Sec. 1396 et seq.), other than coverage  
26 consisting solely of benefits under section 1928;

27 (e) Chapter 55 of Title 10, United States Code (10 U.S.C. Sec. 1071  
28 et seq.);

29 (f) A medical care program of the Indian health service or of a  
30 tribal organization;

31 (g) A state health benefits risk pool;

32 (h) A health plan offered under Chapter 89 of Title 5, United  
33 States Code (5 U.S.C. Sec. 8901 et seq.);

34 (i) The basic health plan as established in chapter 70.47 RCW;

35 (j) The health insurance pool as established in chapter 48.41 RCW;

36 (k) A health benefit plan under section 5(e) of the peace corps act  
37 (22 U.S.C. Sec. 2504(e)); or

1        (1) Any other qualifying coverage required by the health insurance  
2 portability and accountability act of 1996 (HIPAA, Title II), as it may  
3 be amended, or regulations under that act.

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

7        ~~((10))~~ (11) "Eligible employee" means an employee who works on a  
8 full-time basis with a normal work week of thirty or more hours. The  
9 term includes a self-employed individual, including a sole proprietor,  
10 a partner of a partnership, and may include an independent contractor,  
11 if the self-employed individual, sole proprietor, partner, or  
12 independent contractor is included as an employee under a health  
13 benefit plan of a small employer, but does not work less than thirty  
14 hours per week and derives at least seventy-five percent of his or her  
15 income from a trade or business through which he or she has attempted  
16 to earn taxable income and for which he or she has filed the  
17 appropriate internal revenue service form. Persons covered under a  
18 health benefit plan pursuant to the consolidated omnibus budget  
19 reconciliation act of 1986 shall not be considered eligible employees  
20 for purposes of minimum participation requirements of chapter 265, Laws  
21 of 1995.

22        ~~((11))~~ (12) "Eligible individual" means an individual, including  
23 a sole proprietor, who is a resident of Washington state. "Eligible  
24 individual" includes any individual who is eligible for benefits under  
25 section 210 of the federal trade act of 2002, at 26 U.S.C. Sec. 35(c).

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

33        ~~((12))~~ (14) "Emergency services" means otherwise covered health  
34 care services medically necessary to evaluate and treat an emergency  
35 medical condition, provided in a hospital emergency department.

36        ~~((13))~~ (15) "Enrollee point-of-service cost-sharing" means  
37 amounts paid to health carriers directly providing services, health  
38 care providers, or health care facilities by enrollees and may include  
39 copayments, coinsurance, or deductibles.

1        ~~((14))~~ (16) "Exchange" means the Washington state health  
2 insurance exchange established in sections 203 through 205 of this act.

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

11        ~~((15))~~ (18) "Health care facility" or "facility" means hospices  
12 licensed under chapter 70.127 RCW, hospitals licensed under chapter  
13 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,  
14 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes  
15 licensed under chapter 18.51 RCW, community mental health centers  
16 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment  
17 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,  
18 treatment, or surgical facilities licensed under chapter 70.41 RCW,  
19 drug and alcohol treatment facilities licensed under chapter 70.96A  
20 RCW, and home health agencies licensed under chapter 70.127 RCW, and  
21 includes such facilities if owned and operated by a political  
22 subdivision or instrumentality of the state and such other facilities  
23 as required by federal law and implementing regulations.

24        ~~((16))~~ (19) "Health care provider" or "provider" means:

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

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

30        ~~((17))~~ (20) "Health care service" means that service offered or  
31 provided by health care facilities and health care providers relating  
32 to the prevention, cure, or treatment of illness, injury, or disease.

33        ~~((18))~~ (21) "Health carrier" or "carrier" means a disability  
34 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
35 service contractor as defined in RCW 48.44.010, or a health maintenance  
36 organization as defined in RCW 48.46.020.

37        ~~((19))~~ (22) "Health plan" or "health benefit plan" means any  
38 policy, contract, or agreement offered by a health carrier to provide,

1 arrange, reimburse, or pay for health care services except the  
2 following:

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

4 (b) Medicare supplemental health insurance governed by chapter  
5 48.66 RCW;

6 (c) Coverage supplemental to the coverage provided under chapter  
7 55, Title 10, United States Code;

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

10 (e) Disability income;

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

14 (g) Workers' compensation coverage;

15 (h) Accident only coverage;

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

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

19 (k) Dental only and vision only coverage; and

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

27 ~~((+20+))~~ (23) "Material modification" means a change in the  
28 actuarial value of the health plan as modified of more than five  
29 percent but less than fifteen percent.

30 ~~((+21+))~~ (24) "Participating individual" means a person who has  
31 been determined by the exchange to be, and continues to be, an eligible  
32 individual, an employee of a participating employer plan, or a member  
33 of an association health plan for purposes of obtaining coverage  
34 through the exchange. As used in this section, "association health  
35 plan" includes health plans offered through associations, trusts, and  
36 member-governed groups.

37 (25) "Participating employer plan" means a group health plan, as  
38 defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186), that  
39 is sponsored by an employer and for which the plan sponsor has entered

1 into an agreement with the exchange, in accordance with the provisions  
2 of section 207 of this act, for the exchange to offer and administer  
3 health insurance benefits for enrollees in the plan.

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

7 ~~((22))~~ (27) "Premium" means all sums charged, received, or  
8 deposited by a health carrier as consideration for a health plan or the  
9 continuance of a health plan. Any assessment or any "membership,"  
10 "policy," "contract," "service," or similar fee or charge made by a  
11 health carrier in consideration for a health plan is deemed part of the  
12 premium. "Premium" shall not include amounts paid as enrollee point-  
13 of-service cost-sharing.

14 ~~((23))~~ (28) "Review organization" means a disability insurer  
15 regulated under chapter 48.20 or 48.21 RCW, health care service  
16 contractor as defined in RCW 48.44.010, or health maintenance  
17 organization as defined in RCW 48.46.020, and entities affiliated with,  
18 under contract with, or acting on behalf of a health carrier to perform  
19 a utilization review.

20 ~~((24))~~ (29) "Small employer" or "small group" means any person,  
21 firm, corporation, partnership, association, political subdivision,  
22 sole proprietor, or self-employed individual that is actively engaged  
23 in business that, on at least fifty percent of its working days during  
24 the preceding calendar quarter, employed at least two but no more than  
25 fifty eligible employees, with a normal work week of thirty or more  
26 hours, the majority of whom were employed within this state, and is not  
27 formed primarily for purposes of buying health insurance and in which  
28 a bona fide employer-employee relationship exists. In determining the  
29 number of eligible employees, companies that are affiliated companies,  
30 or that are eligible to file a combined tax return for purposes of  
31 taxation by this state, shall be considered an employer. Subsequent to  
32 the issuance of a health plan to a small employer and for the purpose  
33 of determining eligibility, the size of a small employer shall be  
34 determined annually. Except as otherwise specifically provided, a  
35 small employer shall continue to be considered a small employer until  
36 the plan anniversary following the date the small employer no longer  
37 meets the requirements of this definition. A self-employed individual  
38 or sole proprietor must derive at least seventy-five percent of his or  
39 her income from a trade or business through which the individual or

1 sole proprietor has attempted to earn taxable income and for which he  
2 or she has filed the appropriate internal revenue service form 1040,  
3 schedule C or F, for the previous taxable year except for a self-  
4 employed individual or sole proprietor in an agricultural trade or  
5 business, who must derive at least fifty-one percent of his or her  
6 income from the trade or business through which the individual or sole  
7 proprietor has attempted to earn taxable income and for which he or she  
8 has filed the appropriate internal revenue service form 1040, for the  
9 previous taxable year. A self-employed individual or sole proprietor  
10 who is covered as a group of one on the day prior to June 10, 2004,  
11 shall also be considered a "small employer" to the extent that  
12 individual or group of one is entitled to have his or her coverage  
13 renewed as provided in RCW 48.43.035(6).

14 ~~((25))~~ (30) "Utilization review" means the prospective,  
15 concurrent, or retrospective assessment of the necessity and  
16 appropriateness of the allocation of health care resources and services  
17 of a provider or facility, given or proposed to be given to an enrollee  
18 or group of enrollees.

19 ~~((26))~~ (31) "Wellness activity" means an explicit program of an  
20 activity consistent with department of health guidelines, such as,  
21 smoking cessation, injury and accident prevention, reduction of alcohol  
22 misuse, appropriate weight reduction, exercise, automobile and  
23 motorcycle safety, blood cholesterol reduction, and nutrition education  
24 for the purpose of improving enrollee health status and reducing health  
25 service costs.

26 NEW SECTION. **Sec. 37.** CERTIFICATION OF HEALTH BENEFIT PLANS BY  
27 THE OFFICE OF THE INSURANCE COMMISSIONER. (1) Health benefit plans  
28 offered through the exchange established in section 203 of this act  
29 shall be filed with the office of the insurance commissioner.

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

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

35 (b) The plan meets the rating specifications under section 303 of  
36 this act, the preexisting condition provisions under RCW 48.43.015 and  
37 48.43.025, the issue and renewal provisions of RCW 48.43.035, and the  
38 requirements of this section; and



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

3 (3) No plan shall be certified that excludes from coverage any  
4 individual otherwise determined by the exchange as meeting the  
5 eligibility requirements for participating individuals.

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

9 (a) Withdrawal by the commissioner; or

10 (b) Discontinuation of participation in the exchange by the  
11 carrier.

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

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

20 (7) The exchange shall not decline or refuse to offer, or otherwise  
21 restrict the offering to any participating individual, any plan that  
22 has obtained, in a timely fashion in advance of the annual open season,  
23 certification by the commissioner in accordance with the provisions of  
24 this section.

25 (8) The exchange shall not impose on any participating plan or any  
26 carrier or plan seeking to participate in the exchange any terms or  
27 conditions, including any requirements or agreements with respect to  
28 rates or benefits, beyond, or in addition to, those terms and  
29 conditions established and imposed by the commissioner in certifying  
30 plans under the provisions of this section.

31 (9) The commissioner shall establish and administer, rules and  
32 procedures for certifying plans to participate in the exchange, in  
33 accordance with the provisions of this section.

34 (10) Nothing in this section precludes an association or member-  
35 governed group from offering a commissioner-approved plan for purchase  
36 by its members in the exchange such that:

37 (a) Member-governed and association plans are not permitted to  
38 exclude other eligible exchange enrollees from obtaining coverage  
39 through the plan; and

1 (b) Member-governed groups and associations may provide a secondary  
2 level of membership for a nominal monthly fee that allows participation  
3 in said plan by nonmembers.

4 NEW SECTION. **Sec. 38.** HEALTH PLAN RATING METHODOLOGY. Premium  
5 rates for health benefit plans sold through the exchange are subject to  
6 the following provisions:

7 (1)(a) A carrier offering any health benefit plan through the  
8 exchange may offer and actively market a health benefit plan featuring  
9 a limited schedule of covered health care services. Nothing in this  
10 subsection precludes a carrier from offering, or a consumer from  
11 purchasing, other health benefit plans that may have more comprehensive  
12 benefits than those included in the product offered under this  
13 subsection. A carrier offering a health benefit plan under this  
14 subsection shall clearly disclose all covered benefits to consumers in  
15 a brochure filed with the insurance commissioner.

16 (b) A health benefit plan offered under this subsection shall  
17 provide coverage for hospital expenses and services rendered by a  
18 physician licensed under chapter 18.57 or 18.71 RCW but is not subject  
19 to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142,  
20 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200,  
21 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244,  
22 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

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

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

- 31 (a) Geographic area;
- 32 (b) Family size;
- 33 (c) Age; and
- 34 (d) Wellness activities.

35 (4) The adjustment for age in subsection (3)(c) of this section may  
36 not use age brackets smaller than five-year increments, which shall  
37 begin with age twenty and end with age sixty-five. Participating

1 individuals under the age of twenty shall be treated as those age  
2 twenty.

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

7 (6) The permitted rates for any age group shall be no more than  
8 four hundred twenty-five percent of the lowest rate for all age groups.

9 (7) A discount for wellness activities is encouraged to reflect  
10 actuarially justified differences in utilization or cost attributed to  
11 such programs.

12 (8) Rating factors shall produce premiums for identical eligible  
13 individuals that differ only by the amounts attributable to plan  
14 design, with the exception of discounts for health improvement  
15 programs.

16 (9)(a) Except to the extent provided otherwise in (b) of this  
17 subsection, adjusted community rates established under this section  
18 shall pool the medical experience of all eligible individuals  
19 purchasing coverage through the exchange. However, annual rate  
20 adjustments for each health benefit plan offered through the exchange  
21 may vary by up to plus or minus six percentage points from the overall  
22 adjustment of a carrier's entire pool. In addition, high deductible  
23 health plans with health savings accounts are allowed a variance of  
24 plus four or minus eight percentage points from the overall adjustment  
25 of a carrier's entire pool. Any such overall adjustment is to be  
26 approved by the insurance commissioner, upon a showing by the carrier,  
27 certified by a member of the American academy of actuaries that: (i)  
28 The variation is a result of deductible leverage, benefit design, or  
29 provider network characteristics; and (ii) for a rate renewal period,  
30 the projected weighted average of all benefit plans will have a revenue  
31 neutral effect on the carrier's exchange clients. Variations of  
32 greater than six percentage points or minus eight percentage points for  
33 high deductible health plans with health savings accounts, are subject  
34 to review by the commissioner, and must be approved or denied within  
35 sixty days of submittal. A variation that is not denied within sixty  
36 days shall be deemed approved. The commissioner must provide to the  
37 carrier a detailed actuarial justification for any denial within thirty  
38 days of the denial.

1 (b) Carriers may treat persons under age thirty-five as a separate  
2 experience pool for purposes of establishing rates for health plans  
3 approved by the commissioner and available in the exchange. The rates  
4 charged for this age group are not subject to subsection (6) of this  
5 section.

6 **Sec. 39.** RCW 48.43.012 and 2001 c 196 s 6 are each amended to read  
7 as follows:

8 ~~((1))~~ No carrier may reject an individual for ~~((an individual))~~  
9 a health benefit plan through the exchange established in section 203  
10 of this act based upon preexisting conditions of the individual except  
11 as provided in RCW 48.43.018.

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

15 ~~— (3) For an individual health benefit plan originally issued on or~~  
16 ~~after March 23, 2000, preexisting condition waiting periods imposed~~  
17 ~~upon a person enrolling in an individual health benefit plan shall be~~  
18 ~~no more than nine months for a preexisting condition for which medical~~  
19 ~~advice was given, for which a health care provider recommended or~~  
20 ~~provided treatment, or for which a prudent layperson would have sought~~  
21 ~~advice or treatment, within six months prior to the effective date of~~  
22 ~~the plan. No carrier may impose a preexisting condition waiting period~~  
23 ~~on an individual health benefit plan issued to an eligible individual~~  
24 ~~as defined in section 2741(b) of the federal health insurance~~  
25 ~~portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).~~

26 ~~— (4) Individual health benefit plan preexisting condition waiting~~  
27 ~~periods shall not apply to prenatal care services.~~

28 ~~— (5) No carrier may avoid the requirements of this section through~~  
29 ~~the creation of a new rate classification or the modification of an~~  
30 ~~existing rate classification. A new or changed rate classification~~  
31 ~~will be deemed an attempt to avoid the provisions of this section if~~  
32 ~~the new or changed classification would substantially discourage~~  
33 ~~applications for coverage from individuals who are higher than average~~  
34 ~~health risks. These provisions apply only to individuals who are~~  
35 ~~Washington residents.))~~

36 **Sec. 40.** RCW 48.43.015 and 2004 c 192 s 5 are each amended to read  
37 as follows:

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

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

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

15 (b) If the individual applicant's immediately preceding health plan  
16 coverage terminated during the period beginning ninety days and ending  
17 sixty-four days before the date of application for the new plan and  
18 such coverage was similar and continuous for less than three months,  
19 then the carrier shall credit the time covered under the immediately  
20 preceding health plan toward any preexisting condition waiting period  
21 under the new health plan.

22 (c) For the purposes of this subsection, a preceding health plan  
23 includes an employer-provided self-funded health plan, the basic health  
24 plan's offering to health coverage tax credit eligible enrollees as  
25 established by chapter 192, Laws of 2004, and plans of the Washington  
26 state health insurance pool.

27 (3) For a health benefit plan offered (~~(to a small group)~~) through  
28 the exchange established in sections 203 through 205 of this act:

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

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

1 preceding health plan toward any preexisting condition waiting period  
2 under the new health plan.

3 (c) For the purpose of this subsection, a preceding health plan  
4 includes an employer-provided self-funded health plan, the basic health  
5 plan's offering to health coverage tax credit eligible enrollees as  
6 established by chapter 192, Laws of 2004, and plans of the Washington  
7 state health insurance pool.

8 ~~(4) ((For a health benefit plan offered to an individual, other~~  
9 ~~than an individual to whom subsection (5) of this section applies,~~  
10 ~~every health carrier shall credit any preexisting condition waiting~~  
11 ~~period in that plan for a person who was enrolled at any time during~~  
12 ~~the sixty-three day period immediately preceding the date of~~  
13 ~~application for the new health plan in a group health benefit plan or~~  
14 ~~an individual health benefit plan, other than a catastrophic health~~  
15 ~~plan, and (a) the benefits under the previous plan provide equivalent~~  
16 ~~or greater overall benefit coverage than that provided in the health~~  
17 ~~benefit plan the individual seeks to purchase; or (b) the person is~~  
18 ~~seeking an individual health benefit plan due to his or her change of~~  
19 ~~residence from one geographic area in Washington state to another~~  
20 ~~geographic area in Washington state where his or her current health~~  
21 ~~plan is not offered, if application for coverage is made within ninety~~  
22 ~~days of relocation; or (c) the person is seeking an individual health~~  
23 ~~benefit plan: (i) Because a health care provider with whom he or she~~  
24 ~~has an established care relationship and from whom he or she has~~  
25 ~~received treatment within the past twelve months is no longer part of~~  
26 ~~the carrier's provider network under his or her existing Washington~~  
27 ~~individual health benefit plan; and (ii) his or her health care~~  
28 ~~provider is part of another carrier's provider network; and (iii)~~  
29 ~~application for a health benefit plan under that carrier's provider~~  
30 ~~network individual coverage is made within ninety days of his or her~~  
31 ~~provider leaving the previous carrier's provider network. The carrier~~  
32 ~~must credit the period of coverage the person was continuously covered~~  
33 ~~under the immediately preceding health plan toward the waiting period~~  
34 ~~of the new health plan. For the purposes of this subsection (4), a~~  
35 ~~preceding health plan includes an employer-provided self-funded health~~  
36 ~~plan, the basic health plan's offering to health coverage tax credit~~  
37 ~~eligible enrollees as established by chapter 192, Laws of 2004, and~~  
38 ~~plans of the Washington state health insurance pool.~~

1 ~~(5) Every health carrier shall waive any preexisting condition~~  
2 ~~waiting period in its individual plans for a person who is an eligible~~  
3 ~~individual as defined in section 2741(b) of the federal health~~  
4 ~~insurance portability and accountability act of 1996 (42 U.S.C. Sec.~~  
5 ~~300gg-41(b)).~~

6 ~~(6))~~ Subject to the provisions of subsections (1) through ~~((5))~~  
7 (3) of this section, nothing contained in this section requires a  
8 health carrier to amend a health plan to provide new benefits in its  
9 existing health plans. In addition, nothing in this section requires  
10 a carrier to waive benefit limitations not related to an individual or  
11 group's preexisting conditions or health history.

12 **Sec. 41.** RCW 48.43.018 and 2004 c 244 s 3 are each amended to read  
13 as follows:

14 (1) Except as provided in (a) through (e) of this subsection, ~~((a~~  
15 ~~health carrier may))~~ the exchange established in section 203 of this  
16 act shall require any person applying ~~((for))~~ as an individual, outside  
17 of a plan permitted under federal law, 26 U.S.C. Sec. 125, for a health  
18 benefit plan, to complete the standard health questionnaire designated  
19 under chapter 48.41 RCW. The health questionnaire shall be kept by the  
20 exchange and shall be provided upon the request of any carrier  
21 receiving an application from an individual, separate from any employer  
22 plan, for coverage, and without such individual providing proof of  
23 creditable coverage lasting eighteen consecutive months or more.

24 (a) If a person is seeking ~~((an individual))~~ a health benefit plan  
25 due to his or her change of residence from one geographic area in  
26 Washington state to another geographic area in Washington state where  
27 his or her current health plan is not offered, completion of the  
28 standard health questionnaire shall not be a condition of coverage if  
29 application for coverage is made within ninety days of relocation.

30 (b) If a person is seeking ~~((an individual))~~ a health benefit plan:

31 (i) Because a health care provider with whom he or she has an  
32 established care relationship and from whom he or she has received  
33 treatment within the past twelve months is no longer part of the  
34 carrier's provider network under his or her existing Washington  
35 ~~((individual))~~ health benefit plan; and

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

1 (iii) Application for a health benefit plan under that carrier's  
2 provider network (~~(individual)~~) coverage is made within ninety days of  
3 his or her provider leaving the previous carrier's provider network;  
4 then completion of the standard health questionnaire shall not be a  
5 condition of coverage.

6 (c) If a person is seeking (~~(an individual)~~) a health benefit plan  
7 due to his or her having exhausted continuation coverage provided under  
8 29 U.S.C. Sec. 1161 et seq., completion of the standard health  
9 questionnaire shall not be a condition of coverage if application for  
10 coverage is made within ninety days of exhaustion of continuation  
11 coverage. A health carrier shall accept an application without a  
12 standard health questionnaire from a person currently covered by such  
13 continuation coverage if application is made within ninety days prior  
14 to the date the continuation coverage would be exhausted and the  
15 effective date of the individual coverage applied for is the date the  
16 continuation coverage would be exhausted, or within ninety days  
17 thereafter.

18 (d) If a person is seeking (~~(an individual)~~) a health benefit plan  
19 due to his or her receiving notice that his or her coverage under a  
20 conversion contract is discontinued, 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 discontinuation of eligibility  
23 under the conversion contract. A health carrier shall accept an  
24 application without a standard health questionnaire from a person  
25 currently covered by such conversion contract if application is made  
26 within ninety days prior to the date eligibility under the conversion  
27 contract would be discontinued and the effective date of the  
28 (~~(individual)~~) coverage applied for is the date eligibility under the  
29 conversion contract would be discontinued, or within ninety days  
30 thereafter.

31 (e) If a person is seeking (~~(an individual)~~) a health benefit plan  
32 and, but for the number of persons employed by his or her employer,  
33 would have qualified for continuation coverage provided under 29 U.S.C.  
34 Sec. 1161 et seq., completion of the standard health questionnaire  
35 shall not be a condition of coverage if: (i) Application for coverage  
36 is made within ninety days of a qualifying event as defined in 29  
37 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months  
38 of continuous group coverage immediately prior to the qualifying event.  
39 A health carrier shall accept an application without a standard health



1 questionnaire from a person with at least twenty-four months of  
2 continuous group coverage if application is made no more than ninety  
3 days prior to the date of a qualifying event and the effective date of  
4 the individual coverage applied for is the date of the qualifying  
5 event, or within ninety days thereafter.

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

9 (a) The carrier may decide not to accept the person's application  
10 for enrollment in its (~~(individual)~~) health benefit plan; and

11 (b) Within fifteen business days of receipt of a completed  
12 application, the carrier shall provide written notice of the decision  
13 not to accept the person's application for enrollment to both the  
14 person and the administrator of the Washington state health insurance  
15 pool. The notice to the person shall state that the person is eligible  
16 for health insurance provided by the Washington state health insurance  
17 pool, and shall include information about the Washington state health  
18 insurance pool and an application for such coverage. If the carrier  
19 does not provide or postmark such notice within fifteen business days,  
20 the application is deemed approved.

21 (3) If the person applying for (~~(an individual)~~) a health benefit  
22 plan: (a) Does not qualify for coverage under the Washington state  
23 health insurance pool based upon the results of the standard health  
24 questionnaire; (b) does qualify for coverage under the Washington state  
25 health insurance pool based upon the results of the standard health  
26 questionnaire and the carrier elects to accept the person for  
27 enrollment; or (c) is not required to complete the standard health  
28 questionnaire designated under this chapter under subsection (1)(a) or  
29 (b) of this section, the carrier shall accept the person for enrollment  
30 if he or she resides within the carrier's service area and provide or  
31 assure the provision of all covered services regardless of age, sex,  
32 family structure, ethnicity, race, health condition, geographic  
33 location, employment status, socioeconomic status, other condition or  
34 situation, or the provisions of RCW 49.60.174(2). The commissioner may  
35 grant a temporary exemption from this subsection if, upon application  
36 by a health carrier, the commissioner finds that the clinical,  
37 financial, or administrative capacity to serve existing enrollees will  
38 be impaired if a health carrier is required to continue enrollment of  
39 additional eligible individuals.

1       **Sec. 42.** RCW 48.43.025 and 2001 c 196 s 9 are each amended to read  
2 as follows:

3       (1) For group health benefit plans for groups other than small  
4 groups, no carrier may reject an individual for health plan coverage  
5 based upon preexisting conditions of the individual and no carrier may  
6 deny, exclude, or otherwise limit coverage for an individual's  
7 preexisting health conditions; except that a carrier may impose a  
8 three-month benefit waiting period for preexisting conditions for which  
9 medical advice was given, or for which a health care provider  
10 recommended or provided treatment within three months before the  
11 effective date of coverage. Any preexisting condition waiting period  
12 or limitation relating to pregnancy as a preexisting condition shall be  
13 imposed only to the extent allowed in the federal health insurance  
14 portability and accountability act of 1996.

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

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

36       **Sec. 43.** RCW 48.43.035 and 2004 c 244 s 4 are each amended to read  
37 as follows:

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

4 (1) Except as provided in RCW 48.43.018, all health carriers shall  
5 accept for enrollment any state resident within the group to whom the  
6 plan is offered and within the carrier's service area and provide or  
7 assure the provision of all covered services regardless of age, sex,  
8 family structure, ethnicity, race, health condition, geographic  
9 location, employment status, socioeconomic status, other condition or  
10 situation, or the provisions of RCW 49.60.174(2). The insurance  
11 commissioner may grant a temporary exemption from this subsection, if,  
12 upon application by a health carrier the commissioner finds that the  
13 clinical, financial, or administrative capacity to serve existing  
14 enrollees will be impaired if a health carrier is required to continue  
15 enrollment of additional eligible individuals.

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

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

27 (a) Nonpayment of premium;

28 (b) Violation of published policies of the carrier approved by the  
29 insurance commissioner;

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

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

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

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

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

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

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

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

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

26 (d) A carrier discontinues offering all health coverage in the  
27 small group market or for groups of up to two hundred, or both markets,  
28 in the state and discontinues coverage under all existing group health  
29 benefit plans in the applicable market involved if: (i) The carrier  
30 provides notice to the commissioner of its intent to discontinue  
31 offering all such coverage in the state and its intent to discontinue  
32 coverage under all such existing health benefit plans at least one  
33 hundred eighty days prior to the date of the discontinuation of  
34 coverage under all such existing health benefit plans; and (ii) the  
35 carrier provides notice to each covered group of the intent to  
36 discontinue the existing health benefit plan at least one hundred  
37 eighty days prior to the date of discontinuation. In the case of  
38 discontinuation under this subsection, the carrier may not issue any  
39 group health coverage in this state in the applicable group market

1 involved for a five-year period beginning on the date of the  
2 discontinuation of the last health benefit plan not so renewed. This  
3 subsection (4) does not require a carrier to provide notice to the  
4 commissioner of its intent to discontinue offering a health benefit  
5 plan to new applicants when the carrier does not discontinue coverage  
6 of existing enrollees under that health benefit plan; or

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

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

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

22 NEW SECTION. **Sec. 44.** INSURANCE MARKET CONSOLIDATION. (1) A  
23 carrier shall not issue or renew an individual health benefit plan,  
24 other than through the exchange established in section 203 of this act,  
25 after January 1, 2009.

26 (2) A carrier shall not issue or renew a small group health benefit  
27 plan, including a plan offered through an association or  
28 member-governed group whether or not formed specifically for the  
29 purpose of purchasing health care, other than through the exchange  
30 established in section 203 of this act, after January 1, 2009.

31 NEW SECTION. **Sec. 45.** RULES. The commissioner may adopt any  
32 rules necessary to implement this chapter.

33  
34 NEW SECTION. **Sec. 46.** STATEMENT OF COVERAGE FORM. (1) Each  
35 employer in Washington shall annually file with the commissioner a form  
36 for each employee employed within Washington indicating the health

1 insurance coverage status of the employee and the employee's dependents  
2 including the source of coverage and the name of the carrier or plan  
3 sponsor and, if no coverage is indicated:

4 (a) The employee's election to, in lieu of insurance coverage, take  
5 full personal responsibility for any and all health care-related  
6 expenses incurred while without coverage, including but not limited to:  
7 Preventative, emergency, and major medical services;

8 (b) The employee's forfeiture of any and all rights to any  
9 consideration or compensation in lieu of their employers financial  
10 contribution for health care;

11 (c) The employee's election to apply, or not apply, for coverage  
12 through the exchange; and

13 (d) The employee's election to be considered, or not to be  
14 considered, for any publicly financed health insurance program or  
15 premium subsidy program administered by Washington.

16 (2) Each form shall be signed by the individual to whom it  
17 pertains.

18 (3) Each self-employed individual in Washington shall annually file  
19 the same form with the commissioner.

20 (4) The secretary of the department of social and health services  
21 shall annually file the same form with the commissioner on behalf of  
22 all individuals receiving medical assistance benefits through a state-  
23 funded program, excepting such individuals as who are also covered by  
24 Part A or Part B of Title XVIII of the social security act (79 Stat.  
25 291; 42 U.S.C. Sec. 1395c et seq. or 1395j et seq., respectively).

26 (5) For purposes of this section, "health insurance coverage" does  
27 not include any coverage consisting solely of one or more excepted  
28 benefits.

29 (6) The commissioner shall prepare and distribute such forms.

30 NEW SECTION. **Sec. 47.** HIGH-RISK TRANSFER POOL TASK FORCE. (1)  
31 The insurance market of Washington state can benefit from a more  
32 effective model for transferring high-risk claims among health  
33 insurance carriers.

34 (a) Carriers already pay for half of all high-risk claims through  
35 assessments that go toward the health insurance pool;

36 (b) Consumers are asked to share in that responsibility with higher  
37 premium costs; and

1 (c) Because they are the most directly affected by any high-risk  
2 transfer system, carriers are best suited to develop and come to  
3 agreement with the commissioner on a model that would effectively  
4 balance risk among carriers but not artificially shift costs to  
5 average-risk consumers or the state.

6 (2) On a date no later than September 1, 2007, the insurance  
7 commissioner shall convene a high-risk transfer pool task force  
8 consisting of representatives from each insurance carrier licensed to  
9 sell health benefit plans in Washington state as of January 1, 2007.

10 (3) A series of meetings shall be held among all task force members  
11 at a location to be determined by the commissioner. The following  
12 parameters apply:

13 (a) Discussion shall be limited to risk transfer solutions that  
14 minimize or exclude any state subsidy and preserve the affordability of  
15 insurance products for all state residents; and

16 (b) Such discussion shall examine the potential for leveraging  
17 additional federal funds for lower-income pool participants.

18 (4) In direct consultation with the commissioner, the task force  
19 members shall develop a risk transfer proposal that will best serve the  
20 exchange, its carriers, and its enrollees for transferring high-risk  
21 claims evenly among carriers.

22 (5) The task force shall consider active and proposed models from  
23 other states that function to spread high risk in the most equitable  
24 manner possible.

25 (6) The task force shall complete its work on a date no later than  
26 January 1, 2008, and shall publish a final report for public  
27 consumption.

28 (7) The final report shall be submitted to the house of  
29 representatives and senate health care committees for expedient  
30 consideration and further action.

31  
32 NEW SECTION. **Sec. 48.** Part headings and captions used in this act  
33 are not any part of the law.

34 NEW SECTION. **Sec. 49.** The following acts or parts of acts are  
35 each repealed, effective January 1, 2009:

- 1 (1) RCW 48.01.260 (Health benefit plans--Carriers--Clarification)  
2 and 2000 c 79 s 40;
- 3 (2) RCW 48.20.025 (Schedule of rates for individual health benefit  
4 plans--Loss ratio--Remittance of premiums--Definitions) and 2003 c 248  
5 s 8, 2001 c 196 s 1, & 2000 c 79 s 3;
- 6 (3) RCW 48.20.028 (Calculation of premiums--Adjusted community  
7 rating method--Definitions) and 2006 c 100 s 1, 2000 c 79 s 4, 1997 c  
8 231 s 207, & 1995 c 265 s 13;
- 9 (4) RCW 48.20.029 (Calculation of premiums--Members of a purchasing  
10 pool--Adjusted community rating method--Definitions) and 2006 c 100 s  
11 2;
- 12 (5) RCW 48.21.045 (Health plan benefits for small employers--  
13 Coverage--Exemption from statutory requirements--Premium rates--  
14 Requirements for providing coverage for small employers--Definitions)  
15 and 2004 c 244 s 1, 1995 c 265 s 14, & 1990 c 187 s 2;
- 16 (6) RCW 48.21.047 (Requirements for plans offered to small  
17 employers--Definitions) and 2005 c 223 s 11 & 1995 c 265 s 22;
- 18 (7) RCW 48.43.038 (Individual health plans--Guarantee of continuity  
19 of coverage--Exceptions) and 2000 c 79 s 25;
- 20 (8) RCW 48.43.041 (Individual health benefit plans--Mandatory  
21 benefits) and 2000 c 79 s 26;
- 22 (9) RCW 48.44.017 (Schedule of rates for individual contracts--Loss  
23 ratio--Remittance of premiums--Definitions) and 2001 c 196 s 11 & 2000  
24 c 79 s 29;
- 25 (10) RCW 48.44.021 (Calculation of premiums--Members of a  
26 purchasing pool--Adjusted community rating method--Definitions) and  
27 2006 c 100 s 4;
- 28 (11) RCW 48.44.022 (Calculation of premiums--Adjusted community  
29 rate--Definitions) and 2006 c 100 s 3, 2004 c 244 s 6, 2000 c 79 s 30,  
30 1997 c 231 s 208, & 1995 c 265 s 15;
- 31 (12) RCW 48.44.023 (Health plan benefits for small employers--  
32 Coverage--Exemption from statutory requirements--Premium rates--  
33 Requirements for providing coverage for small employers) and 2004 c 244  
34 s 7, 1995 c 265 s 16, & 1990 c 187 s 3;
- 35 (13) RCW 48.44.024 (Requirements for plans offered to small  
36 employers--Definitions) and 2003 c 248 s 15 & 1995 c 265 s 23;
- 37 (14) RCW 48.46.062 (Schedule of rates for individual agreements--  
38 Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 12 &  
39 2000 c 79 s 32;



1 (15) RCW 48.46.063 (Calculation of premiums--Members of a  
2 purchasing pool--Adjusted community rating method--Definitions) and  
3 2006 c 100 s 6;

4 (16) RCW 48.46.064 (Calculation of premiums--Adjusted community  
5 rate--Definitions) and 2006 c 100 s 5, 2004 c 244 s 8, 2000 c 79 s 33,  
6 1997 c 231 s 209, & 1995 c 265 s 17;

7 (17) RCW 48.46.066 (Health plan benefits for small employers--  
8 Coverage--Exemption from statutory requirements--Premium rates--  
9 Requirements for providing coverage for small employers) and 2004 c 244  
10 s 9, 1995 c 265 s 18, & 1990 c 187 s 4;

11 (18) RCW 48.46.068 (Requirements for plans offered to small  
12 employers--Definitions) and 2003 c 248 s 16 & 1995 c 265 s 24;

13 (19) RCW 70.47A.010 (Finding--Intent) and 2006 c 255 s 1;

14 (20) RCW 70.47A.020 (Definitions) and 2006 c 255 s 2;

15 (21) RCW 70.47A.030 (Program established--Administrator duties) and  
16 2006 c 255 s 3;

17 (22) RCW 70.47A.040 (Premium subsidies--Enrollment verification,  
18 status changes--Administrator duties--Rules) and 2006 c 255 s 4;

19 (23) RCW 70.47A.050 (Enrollment to remain within appropriation) and  
20 2006 c 255 s 5;

21 (24) RCW 70.47A.060 (Rules) and 2006 c 255 s 6;

22 (25) RCW 70.47A.070 (Reports) and 2006 c 255 s 7;

23 (26) RCW 70.47A.080 (Small employer health insurance partnership  
24 program account) and 2006 c 255 s 8;

25 (27) RCW 70.47A.090 (State children's health insurance program--  
26 Federal waiver request) and 2006 c 255 s 9; and

27 (28) RCW 70.47A.900 (Captions not law--2006 c 255) and 2006 c 255  
28 s 11.

29 NEW SECTION. **Sec. 50.** Sections 38 through 42 of this act take  
30 effect January 1, 2009.

31 Renumber remaining sections consecutively and correct any internal  
32 references accordingly.

--- END ---

**EFFECT:** The amendment creates a health insurance exchange for the individual small group market in the state of Washington.

**2SSB 5930 - S AMD 170**

By Senator Pflug

**PULLED 3/9/2007**

On page 46, line 21 of the title amendment, after "41.05.075" strike "and 41.05.540" and insert "41.05.540; 41.05.021; 48.43.005; 48.43.012; 48.43.015; 48.43.018; 48.43.025; and 48.43.035"

On page 47, line 1 of the title amendment, after "sections" insert "repealing RCW 70.47A.06; 70.47A.070; 70.47A.080; 70.47A.090; 70.47A.900; 48.01.260; 48.20.025; 48.20.028; 48.20.029; 48.21.047; 48.43.038; 48.43.041; 48.44.017; 48.44.021; 48.44.022; 48.44.023; 48.44.024; 48.46.062; 48.46.063; 48.46.064; 48.46.068; 70.47A.010; 70.47A.020; 70.47A.030; 70.47A.040; and 70.47A.050"

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