2SHB 2319 - H AMD TO H AMD (H-4275.1/12) **1080**
By Representative Schmick

FAILED 02/11/2012

On page 1 of the striking amendment, strike all material after line 2 and insert the following:

"**PART I**

DEFINITIONS

Sec. 1. RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are each reenacted and amended to read as follows:

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

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

(2) "Adverse benefit determination" means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including a denial, reduction, termination, or failure to provide or make payment that is based on a determination of an enrollee's or applicant's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(3) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

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

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

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

(7)(a) For grandfathered health benefit plans issued before January 1, 2014, and renewed thereafter, "catastrophic health plan" means:

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

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

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

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

(c) For health benefit plans issued on or after January 1, 2014, "catastrophic health plan" means:

(i) A health benefit plan that meets the definition of catastrophic plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended; or

(ii) A health benefit plan offered outside the exchange marketplace that requires a calendar year deductible or out-of-pocket expenses under the plan, other than for premiums, for covered benefits, that meets or exceeds the commissioner's annual adjustment under (b) of this subsection.

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

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

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

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

(12) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including

severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

(13) "Emergency services" means a medical screening examination, as required under section 1867 of the social security act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the social security act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

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

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

(16) "Final external review decision" means a determination by an independent review organization at the conclusion of an external review.

(17) "Final internal adverse benefit determination" means an adverse benefit determination that has been upheld by a health plan or carrier at the completion of the internal appeals process, or an adverse benefit determination with respect to which the internal

appeals process has been exhausted under the exhaustion rules described in RCW 48.43.530 and 48.43.535.

(18) "Grandfathered health plan" means a group health plan or an individual health plan that under section 1251 of the patient protection and affordable care act, P.L. 111-148 (2010) and as amended by the health care and education reconciliation act, P.L. 111-152 (2010) is not subject to subtitles A or C of the act as amended.

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

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

(21) "Health care provider" or "provider" means:

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

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

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

(23) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

(i) Specified disease or illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance offered as an independent, noncoordinated benefit;

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

(k) Dental only and vision only coverage; and

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

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

(26) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants may enroll in a carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

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

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

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

(30) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in

business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year.

(31) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(32) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

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

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

PART II

THE WASHINGTON HEALTH BENEFIT EXCHANGE

Sec. 2. RCW 43.71.020 and 2011 c 317 s 3 are each amended to read as follows:

(1) The Washington health benefit exchange is established and constitutes a public-private partnership separate and distinct from the state, exercising functions delineated in chapter 317, Laws of 2011. By January 1, 2014, the exchange shall operate consistent with the affordable care act subject to statutory authorization. The exchange shall have a governing board consisting of persons with expertise in the Washington health care system and private and public health care coverage. The initial membership of the board shall be appointed as follows:

(a) By October 1, 2011, each of the two largest caucuses in both the house of representatives and the senate shall submit to the governor a list of five nominees who are not legislators or employees of the state or its political subdivisions, with no caucus submitting the same nominee.

(i) The nominations from the largest caucus in the house of representatives must include at least one employee benefit specialist;

(ii) The nominations from the second largest caucus in the house of representatives must include at least one health economist or actuary;

(iii) The nominations from the largest caucus in the senate must include at least one representative of health consumer advocates;

(iv) The nominations from the second largest caucus in the senate must include at least one representative of small business;

(v) The remaining nominees must have demonstrated and acknowledged expertise in at least one of the following areas: Individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

(b) By December 15, 2011, the governor shall appoint two members from each list submitted by the caucuses under (a) of this subsection. The appointments made under this subsection (1)(b) must include at least one employee benefits specialist, one health economist or actuary, one representative of small business, and one representative of health consumer advocates. The remaining four members must have a demonstrated and acknowledged expertise in at least one of the following areas: Individual health care coverage, small employer health care coverage, health benefits plan administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system.

(c) By December 15, 2011, the governor shall appoint a ninth member to serve as chair. The chair may not be an employee of the state or its political subdivisions. The chair shall serve as a nonvoting member except in the case of a tie. <u>The chair shall serve at the pleasure of the governor.</u>

(d) The following members shall serve as nonvoting, ex officio members of the board:

(i) The insurance commissioner or his or her designee; and

(ii) The administrator of the health care authority, or his or her designee.

(2) Initial members of the board shall serve staggered terms not to exceed four years. Members appointed thereafter shall serve two-year terms.

(3) A member of the board whose term has expired or who otherwise leaves the board shall be replaced by gubernatorial appointment. When the person leaving was nominated by one of the caucuses of the house of representatives or the senate, his or her replacement shall be appointed from a list of five nominees submitted by that caucus within thirty days after the person leaves. If the member to be replaced is the chair, the governor shall appoint a new chair within thirty days after the vacancy occurs. A person appointed to replace a member who leaves the board prior to the expiration of his or her term shall serve only the duration of the unexpired term. Members of the board may be reappointed to multiple terms.

(4) No board member may be appointed if his or her participation in the decisions of the board could benefit his or her own financial interests or the financial interests of an entity he or she represents. No board member may be a lobbyist registered under RCW 42.17A.600. A board member who develops such a conflict of interest or who is a registered lobbyist shall resign or be removed from the board.

(5) Members of the board must be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. Meetings of the board are at the call of the chair.

(6) The exchange and the board are subject only to the provisions of chapter 42.30 RCW, the open public meetings act, and chapter 42.56 RCW, the public records act, and not to any other law or regulation generally applicable to state agencies. Consistent with the open public meetings act, the board may hold executive sessions to consider proprietary or confidential nonpublished information.

(7)(a) The board shall establish an advisory committee to allow for the views of the health care industry and other stakeholders to be heard in the operation of the health benefit exchange.

(b) The board may establish technical advisory committees or seek the advice of technical experts when necessary to execute the powers and duties included in chapter 317, Laws of 2011.

(8) Members of the board are not civilly or criminally liable and may not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under chapter 317, Laws of 2011. Nothing in this section prohibits legal actions against the board to enforce the board's statutory or contractual duties or obligations.

(9) In recognition of the government-to-government relationship between the state of Washington and the federally recognized tribes in the state of Washington, the board shall consult with the American Indian health commission.

Sec. 3. RCW 43.71.030 and 2011 c 317 s 4 are each amended to read as follows:

(1) The exchange may, consistent with the purposes of this chapter: (a) Sue and be sued in its own name; (b) make and execute agreements, contracts, and other instruments, with any public or private person or entity; (c) employ, contract with, or engage personnel; (d) pay administrative costs; and (e) accept grants, donations, loans of funds, and contributions in money, services, materials or otherwise, from the United States or any of its agencies, from the state of Washington and its agencies or from any other source, and use or expend those moneys, services, materials, or other contributions.

(2) The powers and duties of the exchange and the board are limited to those necessary to apply for and administer grants, establish information technology infrastructure, and undertake

additional ((~~administrative~~)) functions necessary to begin operation of the exchange by January 1, 2014, in a manner consistent with, and not exceeding, the minimum requirements for American health benefit exchanges specified in section 1311(d) of P.L. 111-148 of 2010, as amended. Any actions relating to substantive issues ((~~included in RCW 43.71.040~~)) must be consistent with statutory direction on those issues.

NEW SECTION. **Sec. 4.** A new section is added to chapter 43.71 RCW to read as follows:

(1) A person or entity functioning as a navigator under section 1311(i) of P.L. 111-148 of 2010, as amended, may not sell, solicit, or negotiate insurance in this state for any line or lines of insurance unless the person or entity is licensed for that line of authority under RCW 48.17.060.

(2) The exchange shall permit producers licensed under RCW 48.17.060 to enroll qualified individuals, qualified employers, or qualified employees in qualified health plans in the exchange.

(3) Producers licensed under RCW 48.17.060 shall be compensated by qualified health plan issuers in the same manner and amount as the qualified health plan issuer compensates producers for comparable health plan outside of the exchange. The exchange shall have no role in developing or determining the manner or amount of compensation producers receive from qualified health plans for individuals or employers enrolled in health plans through the exchange.

PART III

QUALIFIED HEALTH PLANS

NEW SECTION. **Sec. 5.** A new section is added to chapter 43.71 RCW to read as follows:

(1) The board shall certify a plan as a qualified health plan to be offered through the exchange if the plan:

(a) Is determined by the insurance commissioner to meet the requirements of Title 48 RCW and rules adopted by the commissioner pursuant to chapter 34.05 RCW; and

(b) Meets the requirements for qualified health plans under section 1311(c) of P.L. 111-148 of 2010, as amended.

(2) The board may not impose requirements on qualified health plans other than the requirements in subsection (1) of this section.

(3) A decision by the board denying a request to certify or recertify a plan as a qualified health plan may be appealed pursuant to chapter 34.05 RCW.

Sec. 6. RCW 48.42.010 and 1985 c 264 s 15 are each amended to read as follows:

(1) Notwithstanding any other provision of law, and except as provided in this chapter, any person or other entity which provides coverage in this state for life insurance, annuities, loss of time, medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether the coverage is by direct payment, reimbursement, the providing of services, or otherwise, shall be subject to the authority of the state insurance commissioner, unless the person or other entity shows that while providing the services it is subject to the jurisdiction and regulation of another agency of this state, any subdivisions thereof, or the federal government.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

Sec. 7. RCW 48.42.020 and 1983 c 36 s 2 are each amended to read as follows:

(1) A person or entity may show that it is subject to the jurisdiction and regulation of another agency of this state, any subdivision thereof, or the federal government, by providing to the insurance commissioner the appropriate certificate, license, or other

document issued by the other governmental agency which permits or qualifies it to provide the coverage as defined in RCW 48.42.010.

(2) "Another agency of this state, any subdivision thereof, or the federal government" does not include the Washington health benefit exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43 RCW to read as follows:

Certification by the Washington health benefit exchange of a plan as a qualified health plan, or of a carrier as a qualified issuer, does not exempt the plan or carrier from any of the requirements of this title or rules adopted by the commissioner pursuant to chapter 34.05 RCW.

PART IV

ESSENTIAL HEALTH BENEFITS

NEW SECTION. **Sec. 9.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Consistent with federal law, the commissioner shall, by rule, select the largest small group plan in the state by enrollment, as determined by an independent actuarial analysis, as the benchmark plan for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended, the commissioner shall, by rule, supplement the benchmark plan benefits as needed, but no more than the extent necessary to comply with the minimum standards in federal law.

(3) Any health plan required to offer the essential health benefits under P.L. 111-148 of 2010, as amended, may be offered in the state unless the commissioner finds that:

(a) It is not substantially equal to the benchmark plan; or

(b) It does not cover the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended.

(4) A finding by the commissioner under subsection (3) of this section may be appealed pursuant to chapter 34.05 RCW. In any such proceeding, the insurance commissioner shall have the burden to prove, by clear and convincing evidence, that the plan is not substantially equal to the benchmark plan or does not cover the ten essential health benefits categories.

PART V

THE WASHINGTON STATE HEALTH INSURANCE POOL

Sec. 10. RCW 48.41.060 and 2011 c 314 s 13 are each amended to read as follows:

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies, health care service contractors, and health maintenance organizations, licensed or registered to offer or provide the kinds of health coverage defined under this title. In addition thereto, the board shall:

(a) ((~~Designate or establish the standard health questionnaire to be used under RCW 48.41.100 and 48.43.018, including the form and content of the standard health questionnaire and the method of its application. The questionnaire must provide for an objective evaluation of an individual's health status by assigning a discreet measure, such as a system of point scoring to each individual. The questionnaire must not contain any questions related to pregnancy, and pregnancy shall not be a basis for coverage by the pool. The questionnaire shall be designed such that it is reasonably expected to identify the eight percent of persons who are the most costly to treat who are under individual coverage in health benefit plans, as defined in RCW 48.43.005, in Washington state or are covered by the pool, if applied to all such persons;~~

~~(b) Obtain from a member of the American academy of actuaries, who is independent of the board, a certification that the standard health~~

~~questionnaire meets the requirements of (a) of this subsection;~~

~~(c) Approve the standard health questionnaire and any modifications needed to comply with this chapter. The standard health questionnaire shall be submitted to an actuary for certification, modified as necessary, and approved at least every thirty-six months unless at the time when certification is required the pool will be discontinued before the end of the succeeding thirty-six month period. The designation and approval of the standard health questionnaire by the board shall not be subject to review and approval by the commissioner. The standard health questionnaire or any modification thereto shall not be used until ninety days after public notice of the approval of the questionnaire or any modification thereto, except that the initial standard health questionnaire approved for use by the board after March 23, 2000, may be used immediately following public notice of such approval;~~

~~(d)~~)) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices consistent with Washington state individual plan rating requirements under RCW 48.44.022 and 48.46.064;

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

(ii) Self-funded multiple employer welfare arrangements are subject to assessment under this subsection only in the event that assessments are not preempted by the employee retirement income

security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing assessments on these arrangements before imposing the assessment. Once the legality of the assessments has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these assessments.

(iii) If there has not been a final determination of the legality of these assessments, then beginning on the earlier of (A) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (B) April 1, 2006, the arrangement shall deposit the assessments imposed by this subsection into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the board;

((~~(f)~~)) (c) Issue policies of health coverage in accordance with the requirements of this chapter; and

((~~(g) Establish procedures for the administration of the premium discount provided under RCW 48.41.200(3)(a)(iii);~~

~~(h) Contract with the Washington state health care authority for the administration of the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii);~~

~~(i) Set a reasonable fee to be paid to an insurance producer licensed in Washington state for submitting an acceptable application for enrollment in the pool; and~~

~~(j)~~)) (d) Provide certification to the commissioner when assessments will exceed the threshold level established in RCW 48.41.037.

(2) In addition thereto, the board may:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter including the authority,

with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

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

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

(d) Conduct periodic audits to assure the general accuracy of the financial data submitted to the pool, and the board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

(3) Nothing in this section shall be construed to require or authorize the adoption of rules under chapter 34.05 RCW.

Sec. 11. RCW 48.41.110 and 2011 c 315 s 6 are each amended to read as follows:

(1) The pool shall offer one or more care management plans of coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. The pool may incorporate managed care features into existing plans.

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

(3) The health insurance policies issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of covered illnesses, injuries, and conditions. Eligible expenses are

the reasonable amounts for the health care services and items for which benefits are extended under a pool policy.

(4) The pool shall offer at least two policies, one of which will be a comprehensive policy that must comply with RCW 48.41.120 and must at a minimum include the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, including no less than a total of one hundred eighty inpatient days in a calendar year, and no less than thirty days inpatient care for alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) No less than twenty outpatient professional visits for the diagnosis or treatment of alcohol, drug, or chemical dependency or abuse rendered during a calendar year by a state-certified chemical dependency program approved under chapter 70.96A RCW, or by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not less than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery including at least the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

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

(p) Hospice services;

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

(r) Mental health services pursuant to RCW 48.41.220; and

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

(5) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

(6) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(7)(a) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny,

exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services or extend beyond December 31, 2013. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection (8) of this section.

(b) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen.

(8)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

(b) The pool shall waive any preexisting condition waiting period for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(9) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier,

rather than to the pool, should govern for purposes of determining preexisting condition credit.

(10) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate. The pool may encourage the use of shared decision making and certified decision aids for preference-sensitive care areas.

Sec. 12. RCW 48.41.170 and 1987 c 431 s 17 are each amended to read as follows:

The commissioner shall adopt rules pursuant to chapter 34.05 RCW that((~~:~~

~~(1) Provide for disclosure by the member of the availability of insurance coverage from the pool; and~~

~~(2)~~)) implement this chapter.

NEW SECTION. **Sec. 13.** A new section is added to chapter 48.41 RCW to read as follows:

For policies renewed beginning January 1, 2014, rates for pool coverage may be no more than the average individual standard rate charged for coverage comparable to pool coverage by the five largest members, measured in terms of individual market enrollment, offering such coverages in the state. In the event five members do not offer comparable coverage, rates for pool coverage may be no more than the standard risk rate established using reasonable actuarial techniques and must reflect anticipated experience and expenses for such coverage in the individual market.

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

Only persons enrolled in a health benefit plan through the pool on December 31, 2013, who do not disenroll after December 31, 2013, are eligible for pool coverage.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.41 RCW to read as follows:

(1) The pool may perform all or part of the risk management functions in the federal patient protection and affordable care act pursuant to a state contract providing funding.

(2) To further timely state implementation of the federal patient protection and affordable care act in the state, the pool is authorized to conduct preoperational and planning activities related to these programs, including defining and implementing an appropriate legal structure or structures to administer and coordinate these programs.

(3) Funding for the transitional reinsurance program as provided by assessments pursuant to section 1341 of the federal patient protection and affordable care act may be increased in this state by inclusion of additional assessment amounts to cover the administrative costs of operation of the reinsurance program including reimbursement of the reasonable costs incurred by the pool for preoperational activities undertaken pursuant to this section.

(4) The pool shall report on these activities to the appropriate committees of the senate and house of representatives by December 15, 2012, and December 15, 2013. The reports shall also include recommendations on additional mechanisms to address high-risk individuals both inside and outside of the exchange.

NEW SECTION. **Sec. 16.** The following acts or parts of acts, as now existing or hereafter amended, are each repealed, effective January 1, 2014:

(1) RCW 48.43.018 (Requirement to complete the standard health questionnaire--Exemptions--Results) and 2010 c 277 s 1 & 2009 c 42 s 1;

(2) RCW 48.41.020 (Intent) and 2000 c 79 s 5 & 1987 c 431 s 2;

(3) RCW 48.41.100 (Eligibility for coverage) and 2011 c 315 s 5, 2011 c 314 s 15, 2009 c 555 s 3, 2007 c 259 s 30, 2001 c 196 s 3, 2000 c 79 s 12, 1995 c 34 s 5, 1989 c 121 s 7, & 1987 c 431 s 10; and

(4) RCW 48.41.200 (Rates--Standard risk and maximum) and 2007 c 259 s 28, 2000 c 79 s 17, 1997 c 231 s 214, & 1987 c 431 s 20.

PART VI

MISCELLANEOUS

NEW SECTION. **Sec. 17.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 18.** Sections 10, 12, and 14 of this act take effect January 1, 2014.

NEW SECTION. **Sec. 19.** Sections 2, 3, and 4 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately.

NEW SECTION. **Sec. 20.** Upon a finding by the United States supreme court that any part of P.L. 111-148, as amended, is unconstitutional, or if federal funding is not provided for the premium subsidies in the exchange, the following acts or parts of acts are each repealed:

(1) RCW 43.71.005 (Finding--Intent) and 2011 c 317 s 1;

(2) RCW 43.71.010 (Definitions) and 2011 c 317 s 2;

(3) RCW 43.71.020 (Washington health benefit exchange) and 2012 c ... s 2 (section 2 of this act) & 2011 c 317 s 3;

(4) RCW 43.71.030 (Exchange--Powers and duties) and 2012 c ... s 3 (section 3 of this act) & 2011 c 317 s 4;

(5) RCW 43.71.040 (Authority, joint select committee on health reform, and board--Collaboration--Report--Responsibilities and duties) and 2011 c 317 s 5;

(6) RCW 43.71.050 (Authority--Powers and duties) and 2011 c 317 s 6;

(7) RCW 43.71.060 (Health benefit exchange account) and 2011 c 317 s 7; and

(8) RCW 43.71.900 (Conflict with federal requirements--2011 c 317) and 2011 c 317 s 9."

EFFECT: Removes the lobbying restrictions for voting members of the exchange board; instead, prohibits members of the exchange board from being a registered lobbyist. Requires the exchange to be operated in a manner consistent with, and not exceeding, the federal Affordable Care Act (ACA). Restores language that requires actions by the exchange and the board to be consistent with statutory direction. Removes the authority of the exchange to serve as a premium aggregator and to complete other duties necessary to begin operations. Eliminates language requiring the exchange to be self-sustaining. Removes language requiring the exchange to permit sponsorship of exchange enrollees. Removes language naming the exchange the "Evergreen Health Marketplace." Requires the chair of the exchange board to serve at the pleasure of the governor immediately upon the legislation's enactment, instead of beginning December 1, 2013. Prohibits navigators from selling, soliciting, or negotiating insurance unless the navigator is licensed. Requires the exchange to allow insurance producers to enroll persons and entities in qualified health plans. Requires insurance producers enrolling individuals and entities inside the exchange to be compensated in the same manner as they would be outside the exchange. Eliminates the additional market rules. Eliminates the requirement that plans sold outside the exchange comply with the "metal" levels specified in the ACA. Eliminates the requirement that qualified health plans include tribal clinics and urban Indian clinics in their provider networks. Removes the ability of the exchange to exempt integrated delivery systems from including all essential community providers in provider networks. Removes the authority for stand-alone dental plans to be sold in the exchange. Eliminates the rating system from qualified health plans. Requires appeals of board decisions regarding qualified health plans to be subject to the Administrative Procedure Act. Requires any additional benefits added to the essential health benefits by the Insurance Commissioner to be no more than the extent necessary to comply with federal law. Allows a health plan to be sold in Washington unless the Insurance Commissioner finds that it is not substantially equal to the benchmark or does not cover the 10 essential health benefits categories in the ACA. Requires appeals of the Insurance Commissioner's findings to be subject to the

Administrative Procedure Act - in any such proceeding the Insurance Commissioner has the burden to prove, by clear and convincing evidence, that the plan is not substantially equal to the benchmark or does not cover the 10 essential health benefits categories. Removes language clarifying that the act does not prohibit coverage of tax-deductible spiritual care services. Removes the requirement that the Insurance Commissioner report to the Legislature any mandated benefits that would result in federally imposed state costs and removes the prohibition against funding mandated benefits on the list that are not funded in the omnibus appropriations act. Removes the authority for the state to establish the federal Basic Health Program. Removes the requirement for the Insurance Commissioner to establish the reinsurance risk adjustment programs. Closes the Washington State Health Insurance Pool (WSHIP) to new enrollment beginning January 1, 2014. Removes the requirement that enrollees in the WSHIP be provided with exchange-like premium subsidies. Removes the requirement that the WSHIP evaluate the populations that may need ongoing access to the WSHIP, make recommendations regarding continuing the WSHIP past January 1, 2014, and make recommendations regarding changes to the assessment or any credits that may be considered for the federal reinsurance program. Removes the requirement that the Health Care Authority pursue an application to participate in the individual market wellness program demonstration created in the ACA.

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