

SSB 6178 - S AMD 85
By Senator Becker

1 Strike everything after the enacting clause and insert the
2 following:

3 "PART I
4 DEFINITIONS

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

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

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

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

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

28 (4) "Basic health plan" means the plan described under chapter
29 70.47 RCW, as revised from time to time.

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

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

7 (7)(a) For grandfathered health benefit plans issued before January
8 1, 2014, and renewed thereafter, "catastrophic health plan" means:

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

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

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

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

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

37 (i) A health benefit plan that meets the definition of catastrophic

1 plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended;
2 or

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

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

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

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

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

23 (12) "Emergency medical condition" means a medical condition
24 manifesting itself by acute symptoms of sufficient severity, including
25 severe pain, such that a prudent layperson, who possesses an average
26 knowledge of health and medicine, could reasonably expect the absence
27 of immediate medical attention to result in a condition (a) placing the
28 health of the individual, or with respect to a pregnant woman, the
29 health of the woman or her unborn child, in serious jeopardy, (b)
30 serious impairment to bodily functions, or (c) serious dysfunction of
31 any bodily organ or part.

32 (13) "Emergency services" means a medical screening examination, as
33 required under section 1867 of the social security act (42 U.S.C.
34 1395dd), that is within the capability of the emergency department of
35 a hospital, including ancillary services routinely available to the
36 emergency department to evaluate that emergency medical condition, and
37 further medical examination and treatment, to the extent they are
38 within the capabilities of the staff and facilities available at the

1 hospital, as are required under section 1867 of the social security act
2 (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect
3 to an emergency medical condition, has the meaning given in section
4 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

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

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

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

15 (17) "Final internal adverse benefit determination" means an
16 adverse benefit determination that has been upheld by a health plan or
17 carrier at the completion of the internal appeals process, or an
18 adverse benefit determination with respect to which the internal
19 appeals process has been exhausted under the exhaustion rules described
20 in RCW 48.43.530 and 48.43.535.

21 (18) "Grandfathered health plan" means a group health plan or an
22 individual health plan that under section 1251 of the patient
23 protection and affordable care act, P.L. 111-148 (2010) and as amended
24 by the health care and education reconciliation act, P.L. 111-152
25 (2010) is not subject to subtitles A or C of the act as amended.

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

34 (20) "Health care facility" or "facility" means hospices licensed
35 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
36 rural health care facilities as defined in RCW 70.175.020, psychiatric
37 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
38 under chapter 18.51 RCW, community mental health centers licensed under

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

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

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

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

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

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

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

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

29 (b) Medicare supplemental health insurance governed by chapter
30 48.66 RCW;

31 (c) Coverage supplemental to the coverage provided under chapter
32 55, Title 10, United States Code;

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

35 (e) Disability income;

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

- 1 (g) Workers' compensation coverage;
2 (h) Accident only coverage;
3 (i) Specified disease or illness-triggered fixed payment insurance,
4 hospital confinement fixed payment insurance, or other fixed payment
5 insurance offered as an independent, noncoordinated benefit;
6 (j) Employer-sponsored self-funded health plans;
7 (k) Dental only and vision only coverage; and
8 (l) Plans deemed by the insurance commissioner to have a short-term
9 limited purpose or duration, or to be a student-only plan that is
10 guaranteed renewable while the covered person is enrolled as a regular
11 full-time undergraduate or graduate student at an accredited higher
12 education institution, after a written request for such classification
13 by the carrier and subsequent written approval by the insurance
14 commissioner.

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

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

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

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

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

1 (30) "Small employer" or "small group" means any person, firm,
2 corporation, partnership, association, political subdivision, sole
3 proprietor, or self-employed individual that is actively engaged in
4 business that employed an average of at least one but no more than
5 fifty employees, during the previous calendar year and employed at
6 least one employee on the first day of the plan year, is not formed
7 primarily for purposes of buying health insurance, and in which a bona
8 fide employer-employee relationship exists. In determining the number
9 of employees, companies that are affiliated companies, or that are
10 eligible to file a combined tax return for purposes of taxation by this
11 state, shall be considered an employer. Subsequent to the issuance of
12 a health plan to a small employer and for the purpose of determining
13 eligibility, the size of a small employer shall be determined annually.
14 Except as otherwise specifically provided, a small employer shall
15 continue to be considered a small employer until the plan anniversary
16 following the date the small employer no longer meets the requirements
17 of this definition. A self-employed individual or sole proprietor who
18 is covered as a group of one must also: (a) Have been employed by the
19 same small employer or small group for at least twelve months prior to
20 application for small group coverage, and (b) verify that he or she
21 derived at least seventy-five percent of his or her income from a trade
22 or business through which the individual or sole proprietor has
23 attempted to earn taxable income and for which he or she has filed the
24 appropriate internal revenue service form 1040, schedule C or F, for
25 the previous taxable year, except a self-employed individual or sole
26 proprietor in an agricultural trade or business, must have derived at
27 least fifty-one percent of his or her income from the trade or business
28 through which the individual or sole proprietor has attempted to earn
29 taxable income and for which he or she has filed the appropriate
30 internal revenue service form 1040, for the previous taxable year.

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

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

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

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

13 **PART II**

14 **THE WASHINGTON HEALTH BENEFIT EXCHANGE**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (3) A member of the board whose term has expired or who otherwise
34 leaves the board shall be replaced by gubernatorial appointment. When
35 the person leaving was nominated by one of the caucuses of the house of
36 representatives or the senate, his or her replacement shall be
37 appointed from a list of five nominees submitted by that caucus within
38 thirty days after the person leaves. If the member to be replaced is

1 the chair, the governor shall appoint a new chair within thirty days
2 after the vacancy occurs. A person appointed to replace a member who
3 leaves the board prior to the expiration of his or her term shall serve
4 only the duration of the unexpired term. Members of the board may be
5 reappointed to multiple terms.

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

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

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

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

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

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

36 (9) In recognition of the government-to-government relationship
37 between the state of Washington and the federally recognized tribes in

1 the state of Washington, the board shall consult with the American
2 Indian health commission.

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

5 (1) The exchange may, consistent with the purposes of this chapter:

6 (a) Sue and be sued in its own name; (b) make and execute agreements,
7 contracts, and other instruments, with any public or private person or
8 entity; (c) employ, contract with, or engage personnel; (d) pay
9 administrative costs; and (e) accept grants, donations, loans of funds,
10 and contributions in money, services, materials or otherwise, from the
11 United States or any of its agencies, from the state of Washington and
12 its agencies or from any other source, and use or expend those moneys,
13 services, materials, or other contributions.

14 (2) The powers and duties of the exchange and the board are limited
15 to those necessary to apply for and administer grants, establish
16 information technology infrastructure, and undertake additional
17 administrative functions as determined by the legislature that are
18 necessary to begin operation of the exchange by January 1, 2014, in a
19 manner consistent with, and not exceeding, the minimum requirements for
20 American health benefit exchanges specified in section 1311(d) of P.L.
21 111-148 of 2010, as amended. Any actions relating to substantive
22 issues (~~included in RCW 43.71.040~~) must be consistent with statutory
23 direction on those issues.

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

26 (1) A person or entity functioning as a navigator under section
27 1311(i) of P.L. 111-148 of 2010, as amended, may not sell, solicit, or
28 negotiate insurance in this state for any line or lines of insurance
29 unless the person or entity is licensed for that line of authority
30 under RCW 48.17.060.

31 (2) The exchange shall permit producers licensed under RCW
32 48.17.060 to enroll qualified individuals, qualified employers, or
33 qualified employees in qualified health plans in the exchange.

34 (3)(a) Producers licensed under RCW 48.17.060 shall be compensated
35 by qualified health plan issuers in the same manner and amount as the
36 qualified health plan issuer compensates producers for comparable

1 health plan outside of the exchange. The exchange shall have no role
2 in developing or determining the manner or amount of compensation
3 producers receive from qualified health plans for individuals or
4 employers enrolled in health plans through the exchange.

5 (b) For the purpose of this subsection (3), "comparable health
6 plan" shall be defined by the issuer, using one of the following
7 determinants: Group size, product, or actuarial value tier specified
8 in section 1302 of P.L. 111-148 of 2010, as amended.

9 **PART III**
10 **QUALIFIED HEALTH PLANS**

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

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

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

18 (b) Meets the requirements for qualified health plans under section
19 1311(c) of P.L. 111-148 of 2010, as amended.

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

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

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

27 (1) Notwithstanding any other provision of law, and except as
28 provided in this chapter, any person or other entity which provides
29 coverage in this state for life insurance, annuities, loss of time,
30 medical, surgical, chiropractic, physical therapy, speech pathology,
31 audiology, professional mental health, dental, hospital, or optometric
32 expenses, whether the coverage is by direct payment, reimbursement, the
33 providing of services, or otherwise, shall be subject to the authority
34 of the state insurance commissioner, unless the person or other entity

1 shows that while providing the services it is subject to the
2 jurisdiction and regulation of another agency of this state, any
3 subdivisions thereof, or the federal government.

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

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

9 (1) A person or entity may show that it is subject to the
10 jurisdiction and regulation of another agency of this state, any
11 subdivision thereof, or the federal government, by providing to the
12 insurance commissioner the appropriate certificate, license, or other
13 document issued by the other governmental agency which permits or
14 qualifies it to provide the coverage as defined in RCW 48.42.010.

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

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

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

25 **PART IV**
26 **ESSENTIAL HEALTH BENEFITS**

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

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

1 (2) If the commissioner determines that the essential health
2 benefits benchmark plan does not include all of the ten benefit
3 categories specified by section 1302 of P.L. 111-148 of 2010, as
4 amended, the commissioner shall, no later than December 15, 2012,
5 recommend to the legislature a supplemental package of benefits that is
6 not more than the extent necessary to comply with the minimum standards
7 in federal law. In making this determination and subsequent
8 recommendation, the commissioner must:

9 (a) Consult with an independent actuary; and

10 (b) Take into account affordability and evidence-based medicine.

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

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

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

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

23 PART V

24 THE WASHINGTON STATE HEALTH INSURANCE POOL

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

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

32 ~~(a) ((Designate or establish the standard health questionnaire to~~
33 ~~be used under RCW 48.41.100 and 48.43.018, including the form and~~
34 ~~content of the standard health questionnaire and the method of its~~
35 ~~application. The questionnaire must provide for an objective~~
36 ~~evaluation of an individual's health status by assigning a discreet~~

1 ~~measure, such as a system of point scoring to each individual. The~~
2 ~~questionnaire must not contain any questions related to pregnancy, and~~
3 ~~pregnancy shall not be a basis for coverage by the pool. The~~
4 ~~questionnaire shall be designed such that it is reasonably expected to~~
5 ~~identify the eight percent of persons who are the most costly to treat~~
6 ~~who are under individual coverage in health benefit plans, as defined~~
7 ~~in RCW 48.43.005, in Washington state or are covered by the pool, if~~
8 ~~applied to all such persons;~~

9 ~~(b) Obtain from a member of the American academy of actuaries, who~~
10 ~~is independent of the board, a certification that the standard health~~
11 ~~questionnaire meets the requirements of (a) of this subsection;~~

12 ~~(c) Approve the standard health questionnaire and any modifications~~
13 ~~needed to comply with this chapter. The standard health questionnaire~~
14 ~~shall be submitted to an actuary for certification, modified as~~
15 ~~necessary, and approved at least every thirty six months unless at the~~
16 ~~time when certification is required the pool will be discontinued~~
17 ~~before the end of the succeeding thirty six month period. The~~
18 ~~designation and approval of the standard health questionnaire by the~~
19 ~~board shall not be subject to review and approval by the commissioner.~~
20 ~~The standard health questionnaire or any modification thereto shall not~~
21 ~~be used until ninety days after public notice of the approval of the~~
22 ~~questionnaire or any modification thereto, except that the initial~~
23 ~~standard health questionnaire approved for use by the board after March~~
24 ~~23, 2000, may be used immediately following public notice of such~~
25 ~~approval;~~

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

36 ~~((e)) (b)(i) Assess members of the pool in accordance with the~~
37 ~~provisions of this chapter, and make advance interim assessments as may~~

1 be reasonable and necessary for the organizational or interim operating
2 expenses. Any interim assessments will be credited as offsets against
3 any regular assessments due following the close of the year.

4 (ii) Self-funded multiple employer welfare arrangements are subject
5 to assessment under this subsection only in the event that assessments
6 are not preempted by the employee retirement income security act of
7 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the
8 commissioner shall initially request an advisory opinion from the
9 United States department of labor or obtain a declaratory ruling from
10 a federal court on the legality of imposing assessments on these
11 arrangements before imposing the assessment. Once the legality of the
12 assessments has been determined, the multiple employer welfare
13 arrangement certified by the insurance commissioner must begin payment
14 of these assessments.

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

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

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

29 ~~(h) Contract with the Washington state health care authority for
30 the administration of the premium discounts provided under RCW
31 48.41.200(3)(a) (i) and (ii);~~

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

35 ~~(j))~~ (d) Provide certification to the commissioner when
36 assessments will exceed the threshold level established in RCW
37 48.41.037.

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

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

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

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

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

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

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

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

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

32 (3) The health insurance policies issued by the pool shall pay only
33 reasonable amounts for medically necessary eligible health care
34 services rendered or furnished for the diagnosis or treatment of
35 covered illnesses, injuries, and conditions. Eligible expenses are the
36 reasonable amounts for the health care services and items for which
37 benefits are extended under a pool policy.

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

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

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

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

23 (d) Drugs and contraceptive devices requiring a prescription;

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

27 (f) Services of a home health agency;

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

30 (h) Oxygen;

31 (i) Anesthesia services;

32 (j) Prostheses, other than dental;

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

35 (l) Diagnostic x-rays and laboratory tests;

36 (m) Oral surgery including at least the following: Fractures of
37 facial bones; excisions of mandibular joints, lesions of the mouth,
38 lip, or tongue, tumors, or cysts excluding treatment for

1 temporomandibular joints; incision of accessory sinuses, mouth salivary
2 glands or ducts; dislocations of the jaw; plastic reconstruction or
3 repair of traumatic injuries occurring while covered under the pool;
4 and excision of impacted wisdom teeth;

5 (n) Maternity care services;

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

8 (p) Hospice services;

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

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

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

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

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

26 (7)(a) The pool may not reject an individual for health plan
27 coverage based upon preexisting conditions of the individual or deny,
28 exclude, or otherwise limit coverage for an individual's preexisting
29 health conditions; except that it shall impose a six-month benefit
30 waiting period for preexisting conditions for which medical advice was
31 given, for which a health care provider recommended or provided
32 treatment, or for which a prudent layperson would have sought advice or
33 treatment, within six months before the effective date of coverage.
34 The preexisting condition waiting period shall not apply to prenatal
35 care services or extend beyond December 31, 2013. The pool may not
36 avoid the requirements of this section through the creation of a new
37 rate classification or the modification of an existing rate

1 classification. Credit against the waiting period shall be as provided
2 in subsection (8) of this section.

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

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

19 (b) The pool shall waive any preexisting condition waiting period
20 for a person who is an eligible individual as defined in section
21 2741(b) of the federal health insurance portability and accountability
22 act of 1996 (42 U.S.C. 300gg-41(b)).

23 (9) If an application is made for the pool policy as a result of
24 rejection by a carrier, then the date of application to the carrier,
25 rather than to the pool, should govern for purposes of determining
26 preexisting condition credit.

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

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

34 (1) The commissioner shall adopt rules pursuant to chapter 34.05
35 RCW that(+

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

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

2 (2) The commissioner shall adopt rules establishing the reinsurance
3 program, as approved by the pool in section 15 of this act and reviewed
4 by the exchange board, consistent with P.L. 111-148 of 2010, as
5 amended. The rules must establish the invisible high risk pool with
6 the following:

7 (a) A mechanism to collect reinsurance contribution funds for
8 individuals ceded to the invisible high risk pool; and

9 (b) A mechanism to disburse reinsurance payments for individuals
10 ceded to the invisible high risk pool.

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

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

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

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

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

29 (1) The pool may perform all or part of the risk management
30 functions in the federal patient protection and affordable care act.

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

1 The legislature also directs the pool to develop and design a plan to
2 administer the state-based reinsurance program as a permanent invisible
3 high risk pool consistent with federal law. The plan must be approved
4 by the pool by December 1, 2012, prior to establishment and
5 implementation and must include a recommendation for the governance
6 structure of the pool if needed to administer any of the risk
7 management functions per subsection (1) of this section. The pool
8 shall, no later than January 1, 2013, make recommendations to the
9 legislature for any statutory changes necessary to implement the plan
10 developed according to this subsection.

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

18 (4) The pool shall report on these activities to the appropriate
19 committees of the senate and house of representatives by December 15,
20 2012, and December 15, 2013. The reports shall also include
21 recommendations on additional mechanisms to address high-risk
22 individuals both inside and outside of the exchange.

23 NEW SECTION. **Sec. 16.** The following acts or parts of acts, as now
24 existing or hereafter amended, are each repealed, effective January 1,
25 2014:

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

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

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

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

34 **PART VI**
35 **MISCELLANEOUS**

1 NEW SECTION. **Sec. 17.** Sections 10, 12, and 14 of this act take
2 effect January 1, 2014.

3 NEW SECTION. **Sec. 18.** Sections 2, 3, and 4 of this act are
4 necessary for the immediate preservation of the public peace, health,
5 or safety, or support of the state government and its existing public
6 institutions, and take effect immediately.

7 NEW SECTION. **Sec. 19.** If any provision of this act or its
8 application to any person or circumstance is held invalid, the
9 remainder of the act or the application of the provision to other
10 persons or circumstances is not affected."

SSB 6178 - S AMD
By Senator

11 On page 1, line 2 of the title, after "act;" strike the remainder
12 of the title and insert "amending RCW 43.71.020, 43.71.030, 48.42.010,
13 48.42.020, 48.41.060, 48.41.110, and 48.41.170; reenacting and amending
14 RCW 48.43.005; adding new sections to chapter 43.71 RCW; adding new
15 sections to chapter 48.43 RCW; adding new sections to chapter 48.41
16 RCW; repealing RCW 48.43.018, 48.41.020, 48.41.100, and 48.41.200;
17 providing effective dates; and declaring an emergency."

EFFECT: Prohibits members of the exchange board from lobbying.
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. Defines "comparable health plan."
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. Deletes authority of the Commissioner to supplement the essential health benefits plan by rule. Requires the Commissioner to make recommendations to the legislature for supplemental benefits. Requires the Commissioner to consult with an independent actuary and HHS prior to making the determination or recommendation. Requires the Commissioner to take into account affordability and evidence-based medicine when making the recommendation. Eliminates the Insurance Commissioner's authority to adopt a rule prohibiting a Bronze plan from being offered outside the exchange unless it is offered inside the exchange. 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 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 the largest small-group plan in the state to be designated as the "benchmark" plan for purposes of determining the essential health benefits. 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 the authority for the state to establish the federal Basic Health Program. Removes the requirement for the Insurance Commissioner to establish the reinsurance program. Removes the requirement that enrollees in the Washington State Health Insurance Pool (WSHIP) be provided with exchange-like premium subsidies. Requires the pool to inform the legislature of statutory changes necessary to implement the invisible reinsurance mechanism it designs. Removes the requirement that the WSHIP be authorized by statute to administer the ACA's risk management functions; instead, allows the WSHIP to administer the risk management functions pursuant to a state contract providing funding.

--- END ---