H-3926.1

SUBSTITUTE HOUSE BILL 2355

State of Washington 65th Legislature 2018 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, McBride, Tharinger, Robinson, Ormsby, Appleton, and Jinkins; by request of Insurance Commissioner)

READ FIRST TIME 01/18/18.

AN ACT Relating to establishment of an individual health insurance market claims-based reinsurance program; amending RCW 48.41.030 and 48.41.090; reenacting and amending RCW 42.56.400; adding a new chapter to Title 48 RCW; creating a new section; and declaring an emergency.

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

NEW SECTION. **Sec. 1.** DEFINITIONS. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Association" means the Washington vaccine association established in chapter 70.290 RCW.

(2) "Attachment point" means the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under the Washington reinsurance program.

(3) "Benefit year" means the calendar year during which an eligible health carrier provides coverage through an individual health plan.

(4) "Board" means the Washington reinsurance program management board.

(5) "Coinsurance rate" means the percentage rate at which the Washington reinsurance program will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(6) "Commissioner" means the insurance commissioner.

(7) "Covered lives" means all persons residing in Washington state who are:

(a) Covered under an individual or group health plan issued or delivered in Washington state or an individual or group health plan that otherwise provides benefits to Washington residents; or

(b) Enrolled in a group health plan administered by a third-party administrator.

(8) "Eligible health carrier" means a health carrier offering nongrandfathered individual health plans to consumers in Washington state.

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

(10) "Health plan" means any arrangement by which persons, including dependents or spouses, have access to hospital and medical benefits or reimbursement including any group or individual disability insurance policy; health care service contract; health maintenance agreement; uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not involving insurance or not governed by Title 48 RCW; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by governmental benefits. "Health plan" does not include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, a direct practice as defined in RCW 48.150.010, coverage provided pursuant to Title XIX of the social security act, 42 U.S.C. Sec. 1396 et seq., or coverage where the federal government is the primary payor, including, but not limited to, coverage provided under

the federal employees health benefit program, the tricare program, or the medicare program.

(11) "Individual health plan" means a health plan as defined in RCW 48.43.005 that is offered by a health carrier to individuals other than in connection with a group health plan, and that is not a grandfathered health plan as defined in RCW 48.43.005.

(12) "Individual market" has the same meaning as in RCW 48.43.005.

(13) "Medicare" means coverage under Title XVIII of the social security act, (42 U.S.C. Sec. 1395 et seq., as amended).

(14) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the Washington reinsurance program.

(15) "Reinsurance cap" means the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, over which the claims costs for benefits are no longer eligible for reinsurance payments.

(16) "Reinsurance payments" means an amount paid by the Washington reinsurance program to an eligible health carrier under the program.

(17) "Reinsurance plan of operation" means the plan of operation proposed by the board and approved by the commissioner under section 4 of this act.

(18) "Third-party administrator" means any person or entity who, on behalf of a health carrier or health care purchaser, receives or collects charges, contributions, or premiums for, or adjusts or settles claims on or for, residents of Washington state or Washington health care providers and facilities.

(19) "Washington reinsurance program," "reinsurance program," or "program" means the state-based reinsurance program established under this chapter.

NEW SECTION. **Sec. 2.** WASHINGTON REINSURANCE PROGRAM—CREATION, ADMINISTRATION, BOARD DUTIES. (1) The Washington reinsurance program is established for the purposes of stabilizing the rates and premiums for individual health plans and providing greater financial certainty to consumers of health insurance in this state.

(2) The program must be operated by the association through the board in accordance with the reinsurance plan of operation approved by the commissioner under section 4 of this act. The association must

appoint the Washington reinsurance program management board consisting of the following members:

(a) The insurance commissioner or his or her designee;

(b) A member representing small employers with fifty or fewer employees;

(c) A member representing self-insured large employers with more than fifty employees;

(d) A member representing fully insured large employers with more than fifty employees;

(e) A member representing third-party administrators;

(f) A member representing health carriers offering individual market coverage in Washington;

(g) A member with technical expertise in reinsurance;

(h) A member of the association's board of directors; and

(i) A public member representing consumers who purchase individual market health insurance in Washington.

(3) The board has the following powers and duties related to operation of the Washington reinsurance program:

(a) Prepare and propose to the association amendments to the articles of organization and bylaws of the association to provide for operation of the Washington reinsurance program;

(b) Prepare and adopt a reinsurance plan of operation as provided in section 4 of this act and submit it to the commissioner for approval;

(c) Conduct all activities in accordance with the reinsurance plan of operation approved by the commissioner under section 4 of this act;

(d) Enter into contracts as necessary to collect and disburse the assessment for reinsurance payments;

(e) Enter into contracts as necessary to operate and administer the Washington reinsurance program;

(f) Sue or be sued, including taking any legal action necessary or proper for the recovery of any assessment for, on behalf of, or against health carriers and third-party administrators or other participating persons for reinsurance payments;

(g) Appoint, from among members of the board, committees as necessary to provide technical assistance in the operation of the program;

(h) Hire independent consultants, including accountants, actuaries, attorneys, investment advisors, and auditors, as the board deems necessary for operation of the Washington reinsurance program;

(i) Conduct periodic audits to assure the general accuracy of the financial data submitted to the program. In designing the audit procedures, the board shall take into consideration the auditing conducted by the federal department of health and human services' risk adjustment program under 42 U.S.C. Sec. 18063;

(j) Cause the reinsurance program to be audited by an independent certified public accountant;

(k) Borrow and repay such working capital, reserve, or other funds as, in the judgment of the board, may be necessary for the operation of the program;

(l) Contract with an entity for program administration. The board may contract with any entity that is under contract with the board on the effective date of this section as needed for operation of the Washington reinsurance program for the period of the current contract. Any subsequent contract for administration of the association's other duties must include duties as may be assigned by the board that are necessary for operation of the Washington reinsurance program for the period during which the program will be in effect; and

(m) Perform any other functions to carry out the reinsurance plan of operation and to affect any or all of the purposes for which the program is organized.

(4) This section does not require or authorize the adoption of rules by the board under chapter 34.05 RCW.

NEW SECTION. **Sec. 3.** EXAMINATION, REPORT, AND ENFORCEMENT. (1) The Washington reinsurance program is subject to examination by the commissioner as provided under chapter 48.03 RCW.

(2) The board shall submit to the commissioner, by November 1st of the year following the applicable benefit year or sixty calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later, a financial report for the applicable benefit year in a form approved by the commissioner. The report must include the following information for the benefit year that is the subject of the report, at a minimum:

(a) Funds deposited in the Washington reinsurance program account created in section 8 of this act;

(b) Requests for reinsurance payments received from eligible health carriers;

(c) Reinsurance payments made to eligible health carriers; and

(d) Administrative and operational expenses incurred for the program.

(3) The report must be posted on the association's web site.

NEW SECTION. **Sec. 4.** REINSURANCE PROGRAM PLAN OF OPERATION. The reinsurance plan of operation for the Washington reinsurance program must be submitted by the board to the commissioner for review and by May 15, 2018, and must be approved by the commissioner by June 1, 2018. The plan of operation must:

(1) Provide for the operation of the Washington reinsurance program separate and apart from the association's other duties;

(2) Establish procedures for the handling and accounting of assets and moneys of the program;

(3) Establish regular times and places for meetings of the board in connection with operation of the program;

(4) Establish data and information requirements for submission of reinsurance payment requests by eligible health carriers, processes for notification of eligible health carriers regarding reinsurance payments and issuing payments, and processes to resolve eligible health carrier appeals related to the amount of reinsurance payments, as provided in section 5 of this act;

(5) Establish procedures for the collection of assessments from all health carriers and third-party administrators to provide for reinsurance claims paid under the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made as provided in section 6 of this act;

(6) Establish procedures for records to be kept of all financial transactions and for an annual fiscal reporting to the commissioner as provided in section 3 of this act;

(7) Establish procedures for the submission of data by the program to the commissioner for preparation of quarterly and annual reports required under the terms of a waiver approved under section 9 of this act;

(8) Determine the amount of contingency funding necessary to ensure the continued operation of the program, not to exceed ten percent of gross program assessments;

(9) Establish procedures to prevent the double-counting of covered lives in the calculation of the assessment in section 6 of this act;

(10) Establish a schedule and procedures for health carriers and third-party administrators to submit annual statements and other reports deemed necessary by the board to calculate the assessment in section 6 of this act; and

(11) Contain additional provisions necessary for the execution of the powers and duties of the program.

NEW SECTION. **Sec. 5.** PROGRAM PAYMENTS TO ELIGIBLE HEALTH CARRIERS. (1)(a) The commissioner shall determine the payment parameters for the program annually, in order to:

(i) Manage the program within available assessment resources and federal funding not to exceed the total program funding authorized by the legislature;

(ii) Mitigate the impact of high-cost individuals on premium rates in the individual market;

(iii) Stabilize or reduce premium rates in the individual market; and

(iv) Increase participation in the individual market.

(b) The payment parameters for benefit year 2019 must be consistent with the parameters included in the state innovation waiver approved by the federal government as provided in section 9 of this act. The payment parameters for subsequent years must be established by the commissioner by March 31st of the year before the applicable benefit year. The commissioner must identify any data needed from the program to determine annual payment parameters for each upcoming benefit year, and such data must be timely provided to the commissioner by the program upon the commissioner's request.

(c) The attachment point for the program must be set by the commissioner at an amount between seventy-five thousand dollars and the reinsurance cap. The coinsurance rate shall be set by the commissioner at a percentage rate between fifty and eighty percent. The reinsurance cap shall be set by the commissioner at an amount between five hundred thousand dollars and one million dollars.

(2) An eligible health carrier becomes eligible for a reinsurance payment when:

(a) The claims costs for the covered benefits of an individual enrolled in the eligible health carrier's individual health plan exceed the attachment point;

(b) The eligible health carrier has implemented care management practices for enrollees who are the subject of reinsurance claims through the program. The eligible health carrier must submit an attestation to the board describing the care management strategies it will use and committing to offer each enrollee on whose behalf it has submitted claims the opportunity to participate in the care management program; and

(c) The eligible health carrier makes its requests for reinsurance payments by April 30th in accordance with any requirements established by the board including, but not limited to, requirements related to the format and structure for submission of claims for reinsurance payments. The claims data needed for submission of claims for reinsurance payments must be drawn from the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 U.S.C. Sec. 18063.

(3) The amount of the reinsurance payment is the product of the coinsurance rate and the carrier's claims costs for the individual enrolled in the eligible health carrier's individual health plan that exceed the attachment point, up to the reinsurance cap.

(4) For each applicable benefit year, on May 30th of the year following the applicable benefit year, the program must send an initial settlement report to each eligible health carrier in response to their final claims submission for the applicable benefit year. By August 1st of the year following the applicable benefit year, after resolution of any appeals related to the amount of reinsurance payments received, the program must disburse all applicable reinsurance payments to an eligible health carrier.

(5)(a) The total annual reinsurance payments made to all eligible health carriers may not exceed two hundred million dollars for any applicable benefit year.

(b)(i) If, for any applicable benefit year, the claims submitted under this section exceed two hundred million dollars, the board must make a pro rata reduction in claims payments necessary to keep reimbursement amounts at or below two hundred million dollars;

(ii) If, for any applicable benefit year, the funds available for reinsurance claims are less than two hundred million dollars and insufficient to fund the claims payments required by this section,

the board must make a pro rata reduction in claims necessary to remain within the funds available for reinsurance payments.

(c) If, for any applicable benefit year, the final disbursement of reinsurance payments to eligible health carriers is less than two hundred million dollars, funds remaining in the Washington reinsurance program account created in section 8 of this act must be used to reduce assessments for the subsequent applicable calendar year or to establish contingency funds consistent with the plan of operation.

NEW SECTION. **Sec. 6.** PROGRAM ASSESSMENTS. (1)(a) All health carriers and third-party administrators must pay an annual assessment under this section. On or before October 1, 2018, and on or before May 15th of each subsequent year, the board must determine the covered lives assessment for the subsequent calendar year and report the amount to the commissioner for review and approval. The board must determine the covered lives assessment in the following manner:

(i) The gross assessment amount must be two hundred million dollars plus anticipated administrative expenses not to exceed one and one-half percent of gross program assessments for the subsequent calendar year. The gross assessment amount calculated in 2018 may include contingency funds. The gross assessment calculated in subsequent years may not include contingency funds.

(ii) The net assessment amount is the gross assessment minus federal funds received under a state innovation waiver approved by the federal government under section 9 of this act, minus any surplus funds to be used to reduce assessments under section 5(5)(c) of this act, minus any other state or federal funds received for the purposes of making reinsurance payments or administering the program.

(iii) Each health carrier's and third-party administrator's assessment is determined based on annual statements and other reports deemed necessary by the board and is determined by multiplying the net assessment amount by a fraction. The numerator of the fraction equals that health carrier's or third-party administrator's total number of covered lives, including spouse and dependents, covered under all health plans in the state offered by that health carrier or administered by that third-party administrator during the preceding calendar year. When calculating the numerator, the board shall use the procedures to prevent the double-counting of lives established in section 4 of this act. The denominator of the fraction equals the

total number of covered lives, including spouse and dependents, covered under all health plans in the state offered by all health carriers and administered by all third-party administrators during the preceding calendar year.

(b) The commissioner must, by October 15, 2018, and May 30th in subsequent years, approve the assessment and notify the board.

(2) A health carrier or third-party administrator is not subject to an assessment under this section if it has fifty or fewer covered lives in Washington.

(3) If an assessment against a health carrier or third-party administrator is prohibited by court order, the assessment for the remaining health carriers and third-party administrators may be adjusted in a manner consistent with subsection (1) of this section to ensure that the net assessment amount calculated in subsection (1)(a)(ii) of this section will be collected.

(4)(a) In developing the procedures for collection of assessments under this chapter, the board must give strong consideration to the procedures used in the federal transitional reinsurance program established under 42 U.S.C. Sec. 18061.

(b) The board must notify, in writing, each health carrier and third-party administrator on behalf of the third-party administrator's clients' health plans of the health carrier's or third-party administrator's estimated total assessment by October 16, 2018, and June 1st of each subsequent year and its payment obligation for the upcoming year. The board must determine a payment schedule for receipt of assessments under this section in accordance with the reinsurance plan of operation. Payment collections may be made no more frequently than quarterly.

(5) Payments are due to the board within forty-five days of the payment schedule determined under subsection (4)(b) of this section. The board must charge interest, which begins to accrue on the forty-sixth day, on amounts received after the forty-five day period. The board may allow each health carrier and third-party administrator in arrears to submit a payment plan, subject to approval by the board and initial payment under an approved payment plan.

(6) The board may abate or defer, in whole or in part, the assessment of a health carrier or third-party administrator if, in the opinion of the board, payment of the assessment would endanger the ability of the health carrier or third-party administrator to fulfill its contractual obligations. If an assessment against a

health carrier or third-party administrator is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other health carriers and third-party administrators in a manner consistent with the basis for assessments in subsection (1) of this section. The health carrier or third-party administrator receiving such abatement or deferment remains liable to the program for the deficiency plus interest at a rate established in the reinsurance plan of operation. Upon receipt of payment of any abatement or deferment by a health carrier or third-party administrator, the board shall adjust future assessments made against other health carriers and third-party administrators under this subsection to reflect receipt of the payment.

(7) The board must submit an annual report to the commissioner listing those health carriers and third-party administrators that failed to remit their assessments.

(8) The board must deposit annual assessments collected under this section, less the reinsurance program's administrative expenses, with the state treasurer to the credit of the Washington reinsurance program account created in section 8 of this act.

(9) If the legislature, after receiving the study and recommendations submitted under section 13 of this act, does not enact an alternative financing source for the program on or before June 30, 2019, the board shall determine and collect assessments as provided in this section until the legislature has enacted an alternative financing source.

(10) A health carrier or third-party administrator must submit any annual statements or other reports deemed necessary by the board to calculate the assessment under this section in a manner consistent with the schedule and procedures in the plan of operation.

NEW SECTION. **Sec. 7.** THIRD-PARTY ADMINISTRATOR—REGISTRATION. (1) A third-party administrator shall register and renew annually with the office of the insurance commissioner, on or before January 1, 2019. Registrants shall report a change of legal name, business name, business address, or business telephone number to the commissioner within ten days after the change.

(2) The commissioner shall define the data elements and procedures necessary to implement this section and may establish a registration and renewal fees. To minimize administrative burdens on third-party administrators, in developing the data elements and

procedures for registration and renewal, the commissioner must, to the extent practicable, adopt the data elements and procedures adopted by the Washington vaccine association under RCW 70.290.075.

NEW SECTION. **Sec. 8.** WASHINGTON REINSURANCE PROGRAM ACCOUNT. (1) The Washington reinsurance program account is created in the custody of the state treasurer. All receipts from assessments collected under section 6 of this act, any funds received by the commissioner or other state agency pursuant to a state innovation waiver approved by the federal government as provided in section 9 of this act, any federal funds received by the commissioner under section 13(3) of this act, and any additional funding specifically appropriated to the account must be deposited in the account. Expenditures from the account shall be used to operate the program and to make reinsurance payments to eligible health carriers under the program. Only the commissioner may authorize expenditures from the account. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. In making expenditures from the account, available federal funding available must be expended first.

(2) The account may maintain an initial cash deficit in the account for a period of no more than one fiscal year to defray its initial program costs. The legislature may make appropriations into the account to reduce program administration costs.

(3) If the reinsurance program is terminated, any funds remaining in the Washington reinsurance program account, after allowances for remaining expenses and costs associated with the termination of the program, must be returned to the health carriers and third-party administrators who have paid an assessment in the most recent assessment period in a manner consistent with the basis for assessments in section 6(1) of this act.

NEW SECTION. **Sec. 9.** STATE INNOVATION WAIVER APPLICATION. (1) The commissioner must apply to the secretary of health and human services under 42 U.S.C. Sec. 18052 for a state innovation waiver to implement the Washington reinsurance program for benefit years beginning January 1, 2019, and future years to maximize federal funding. The waiver application must clearly state that operation of the Washington reinsurance program is contingent on approval of the waiver request.

(2) The commissioner must submit the waiver application to the United States secretary of health and human services on or before April 1, 2018. The commissioner must make a draft application available for tribal consultation and for public review and comment by March 1, 2018. The commissioner must notify the chairs and ranking minority members of the house of representatives health care and wellness committee and appropriations committee and the senate health care committee and ways and means committee, and the board of any federal actions regarding the waiver request.

(3) The office of the insurance commissioner must post on its web site any reports submitted to the federal government on the implementation of a waiver granted under this section.

NEW SECTION. **Sec. 10.** CARRIER RATE FILINGS. The commissioner must require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Washington reinsurance program had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

NEW SECTION. **Sec. 11.** REINSURANCE PROGRAM CONTINGENT ON FEDERAL WAIVER. If the state innovation waiver request in section 9 of this act is not approved, or if an approved waiver is terminated or is not renewed, the association and the board may not operate the Washington reinsurance program, collect assessments, or provide reinsurance payments to eligible health carriers.

NEW SECTION. **Sec. 12.** REQUIRED RULE MAKING. The commissioner may adopt rules necessary to carry out this chapter including, but not limited to, rules prescribing the annual establishment of reinsurance payment parameters and measures to enforce reporting of covered lives, audits of covered lives reporting, and payment of applicable assessments.

NEW SECTION. **Sec. 13.** ALTERNATIVE FINANCING MECHANISMS. (1) The commissioner, in consultation with the office of financial management, the department of revenue, the health care authority, and the health benefit exchange, shall conduct a study and submit recommendations to the legislature related to alternative financing

mechanisms for the Washington reinsurance program. In reviewing alternative financing mechanisms, the commissioner must evaluate the feasibility of a health care paid claims assessment, such as that codified at Michigan Compiled Laws, sections 550.1731 through 550.1741.

(2) The commissioner must solicit input from interested parties in the course of the study and may contract with third parties for actuarial or economic analysis necessary to fully evaluate alternative financing options. The commissioner must submit his or her report to relevant committees of the legislature on or before November 30, 2018.

(3) If additional federal funding to support administration and implementation of state-based reinsurance programs becomes available to states, distinct from an application submitted under section 9 of this act, the commissioner shall notify the relevant policy and fiscal committees of the legislature and pursue such funding to offset assessments associated with the reinsurance program established in this chapter. The commissioner must deposit any funds received under this subsection with the state treasurer to the credit of the Washington reinsurance program account created in section 8 of this act.

NEW SECTION. **Sec. 14.** CIVIL AND CRIMINAL IMMUNITY. The program, health carriers and third-party administrators assessed by the program, the board, officers of the program, employees of the program, contractors of the program and the contractors' employees, officers, and directors, the commissioner, the commissioner's representatives, and the commissioner's employees 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 or inaction, 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 this chapter. This section does not prohibit legal actions against the program to enforce the program's statutory or contractual duties or obligations.

NEW SECTION. **Sec. 15.** (1) The board shall add any assessments received from the Washington state health insurance pool under section 17 of this act to the assessments calculated under section 6 of this act. The board shall collect the assessment, on behalf of the

Washington state health insurance pool, on the next date collections for assessments levied under section 6 of this act are due. The board shall work with the Washington state health insurance pool to synchronize assessment dates for the programs.

(2) Upon receipt of the assessments levied under subsection (1) of this section, the board shall remit any amounts collected on behalf of the Washington state health insurance pool to the Washington state health insurance pool.

Sec. 16. RCW 48.41.030 and 2004 c 260 s 25 are each amended to read as follows:

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

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

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

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

(4) "Commissioner" means the insurance commissioner.

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

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

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

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

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

(10) "Health coverage" means any group or individual disability insurance policy, health care service contract, and health maintenance agreement, except those contracts entered into for the provision of health care services pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not

include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

(14) "Member" means ((~~any commercial insurer which provides disability insurance or stop loss insurance, any health care service contractor, any health maintenance organization licensed under Title 48 RCW, and any self-funded multiple employer welfare arrangement as defined in RCW 48.125.010. "Member" also means the Washington state health care authority as issuer of the state uniform medical plan. "Member" shall also mean, as soon as authorized by federal law, employers and other entities, including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after May 18, 1987. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products or those~~

~~products excluded from the definition of "health coverage" set forth in subsection (10) of this section~~)) a health carrier or third-party administrator subject to a covered lives assessment under section 6 of this act.

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

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

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

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

Sec. 17. RCW 48.41.090 and 2013 2nd sp.s. c 6 s 7 are each amended to read as follows:

(1) Following the close of each accounting year, the pool administrator shall determine the total net cost of pool operation which shall include:

(a) Net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses; and

(b) The amount of pool contributions specified in the state omnibus appropriations act for deposit into the health benefit exchange account under RCW 43.71.060, to assist with the transition of enrollees from the pool into the health benefit exchange created by chapter 43.71 RCW.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction. The numerator of the fraction equals that member's total number of resident insured persons, including spouse and dependents, covered under all health

plans in the state by that member during the preceding calendar year. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, covered under all health plans in the state by all pool members during the preceding calendar year.

(b) ((~~For purposes of calculating the numerator and the denominator under (a) of this subsection:~~

~~(i) All health plans in the state by the state health care authority include only the uniform medical plan;~~

~~(ii) Each ten resident insured persons, including spouse and dependents, under a stop loss plan or the uniform medical plan shall count as one resident insured person;~~

~~(iii) Health plans serving medical care services program clients under RCW 74.09.035 are exempted from the calculation; and~~

~~(iv) Health plans established to serve elderly clients or medicaid clients with disabilities under chapter 74.09 RCW when the plan has been implemented on a demonstration or pilot project basis are exempted from the calculation until July 1, 2009.~~

~~(c)~~)) Except as provided in RCW 48.41.037, any deficit incurred by the pool, including pool contributions for deposit into the health benefit exchange account, shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members. The monthly per member assessment may not exceed the 2013 assessment level. If the maximum assessment is insufficient to cover a pool deficit the assessment shall be used first to pay all incurred losses and pool administrative expenses, with the remainder being available for deposit in the health benefit exchange account.

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

(4) The pool administrator shall transmit assessments calculated under this section to the Washington reinsurance program created in section 2 of this act for collection under section 15 of this act.

(5) Subject to the limitation imposed in subsection (2)((~~(c)~~)) (b) of this section, the pool administrator shall transfer the assessments for pool contributions for the operation of the health benefit exchange to the treasurer for deposit into the health benefit exchange account with the quarterly assessments for 2014 as specified in the state omnibus appropriations act. If assessments exceed actual losses and administrative expenses of the pool and pool contributions for deposit into the health benefit exchange account, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

Sec. 18. RCW 42.56.400 and 2017 3rd sp.s. c 30 s 2 and 2017 c 193 s 2 are each reenacted and amended to read as follows:

The following information relating to insurance and financial institutions is exempt from disclosure under this chapter:

(1) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110;

(2) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW;

(3) The names and individual identification data of either all owners or all insureds, or both, received by the insurance commissioner under chapter 48.102 RCW;

(4) Information provided under RCW 48.30A.045 through 48.30A.060;

(5) Information provided under RCW 48.05.510 through 48.05.535, 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and 48.46.600 through 48.46.625;

(6) Examination reports and information obtained by the department of financial institutions from banks under RCW 30A.04.075, from savings banks under RCW 32.04.220, from savings and loan

associations under RCW 33.04.110, from credit unions under RCW 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and from securities brokers and investment advisers under RCW 21.20.100, all of which is confidential and privileged information;

(7) Information provided to the insurance commissioner under RCW 48.110.040(3);

(8) Documents, materials, or information obtained by the insurance commissioner under RCW 48.02.065, all of which are confidential and privileged;

(9) Documents, materials, or information obtained by the insurance commissioner under RCW 48.31B.015(2) (l) and (m), 48.31B.025, 48.31B.030, and 48.31B.035, all of which are confidential and privileged;

(10) Data filed under RCW 48.140.020, 48.140.030, 48.140.050, and 7.70.140 that, alone or in combination with any other data, may reveal the identity of a claimant, health care provider, health care facility, insuring entity, or self-insurer involved in a particular claim or a collection of claims. For the purposes of this subsection:

(a) "Claimant" has the same meaning as in RCW 48.140.010(2).

(b) "Health care facility" has the same meaning as in RCW 48.140.010(6).

(c) "Health care provider" has the same meaning as in RCW 48.140.010(7).

(d) "Insuring entity" has the same meaning as in RCW 48.140.010(8).

(e) "Self-insurer" has the same meaning as in RCW 48.140.010(11);

(11) Documents, materials, or information obtained by the insurance commissioner under RCW 48.135.060;

(12) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.060;

(13) Confidential and privileged documents obtained or produced by the insurance commissioner and identified in RCW 48.37.080;

(14) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.140;

(15) Documents, materials, or information obtained by the insurance commissioner under RCW 48.17.595;

(16) Documents, materials, or information obtained by the insurance commissioner under RCW 48.102.051(1) and 48.102.140 (3) and (7)(a)(ii);

(17) Documents, materials, or information obtained by the insurance commissioner in the commissioner's capacity as receiver under RCW 48.31.025 and 48.99.017, which are records under the jurisdiction and control of the receivership court. The commissioner is not required to search for, log, produce, or otherwise comply with the public records act for any records that the commissioner obtains under chapters 48.31 and 48.99 RCW in the commissioner's capacity as a receiver, except as directed by the receivership court;

(18) Documents, materials, or information obtained by the insurance commissioner under RCW 48.13.151;

(19) Data, information, and documents provided by a carrier pursuant to section 1, chapter 172, Laws of 2010;

(20) Information in a filing of usage-based insurance about the usage-based component of the rate pursuant to RCW 48.19.040(5)(b);

(21) Data, information, and documents, other than those described in RCW 48.02.210(2) as it existed prior to repeal by 2017 3rd sp.s. c 7 s 2, that are submitted to the office of the insurance commissioner by an entity providing health care coverage pursuant to RCW 28A.400.275 as it existed prior to elimination of the report by 2017 3rd sp.s. c 7 s 1, and 48.02.210 as it existed prior to repeal by 2017 3rd sp.s. c 7 s 2;

(22) Data, information, and documents obtained by the insurance commissioner under RCW 48.29.017;

(23) Information not subject to public inspection or public disclosure under RCW 48.43.730(5);

(24) Documents, materials, or information obtained by the insurance commissioner under chapter 48.05A RCW;

(25) Documents, materials, or information obtained by the insurance commissioner under RCW 48.74.025, 48.74.028, 48.74.100(6), 48.74.110(2) (b) and (c), and 48.74.120 to the extent such documents, materials, or information independently qualify for exemption from disclosure as documents, materials, or information in possession of the commissioner pursuant to a financial conduct examination and exempt from disclosure under RCW 48.02.065; ((~~and~~))

(26) Nonpublic personal health information obtained by, disclosed to, or in the custody of the insurance commissioner, as provided in RCW 48.02.068; ((~~and~~))

(27) Data, information, and documents obtained by the insurance commissioner under RCW 48.02.230;

(28) Data, information, and documents necessary to prepare the state innovation waiver application submitted under section 9 of this act, to determine reinsurance parameters obtained by the commissioner under section 5 of this act and to determine reinsurance claims payments; and

(29) Claims submitted under section 5 of this act.

NEW SECTION. **Sec. 19.** CODIFICATION. Sections 1 through 14 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 20.** SEVERABILITY. 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. 21.** EMERGENCY EFFECTIVE DATE. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

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