
HOUSE BILL 2133

State of Washington 59th Legislature 2005 Regular Session

By Representatives Morrell, Campbell, Cody, Green, Schual-Berke, Clibborn, Moeller, Appleton, Lantz, Williams, Ormsby, Chase and Conway

Read first time 02/18/2005. Referred to Committee on Health Care.

1 AN ACT Relating to access to individual health insurance coverage;
2 amending RCW 42.30.020, 48.18.110, 48.20.025, 48.41.030, 48.41.037,
3 48.41.040, 48.41.060, 48.41.080, 48.41.090, 48.41.100, 48.41.110,
4 48.41.120, 48.41.140, 48.41.160, 48.41.190, 48.41.200, 48.44.017,
5 48.44.020, 48.46.060, 48.46.062, and 70.47.060; reenacting and amending
6 RCW 48.04.010; and providing an effective date.

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

8 **Sec. 1.** RCW 42.30.020 and 1985 c 366 s 1 are each amended to read
9 as follows:

10 As used in this chapter unless the context indicates otherwise:

11 (1) "Public agency" means:

12 (a) Any state board, commission, committee, department, educational
13 institution, or other state agency, including the Washington state
14 health insurance pool established in chapter 48.41 RCW, which is
15 created by or pursuant to statute, other than courts and the
16 legislature;

17 (b) Any county, city, school district, special purpose district, or
18 other municipal corporation or political subdivision of the state of
19 Washington;

1 (c) Any subagency of a public agency which is created by or
2 pursuant to statute, ordinance, or other legislative act, including but
3 not limited to planning commissions, library or park boards,
4 commissions, and agencies;

5 (d) Any policy group whose membership includes representatives of
6 publicly owned utilities formed by or pursuant to the laws of this
7 state when meeting together as or on behalf of participants who have
8 contracted for the output of generating plants being planned or built
9 by an operating agency.

10 (2) "Governing body" means the multimember board, commission,
11 committee, council, or other policy or rule-making body of a public
12 agency, or any committee thereof when the committee acts on behalf of
13 the governing body, conducts hearings, or takes testimony or public
14 comment.

15 (3) "Action" means the transaction of the official business of a
16 public agency by a governing body including but not limited to receipt
17 of public testimony, deliberations, discussions, considerations,
18 reviews, evaluations, and final actions. "Final action" means a
19 collective positive or negative decision, or an actual vote by a
20 majority of the members of a governing body when sitting as a body or
21 entity, upon a motion, proposal, resolution, order, or ordinance.

22 (4) "Meeting" means meetings at which action is taken.

23 **Sec. 2.** RCW 48.04.010 and 2000 c 221 s 8 and 2000 c 79 s 1 are
24 each reenacted and amended to read as follows:

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

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

29 (b) Except under RCW 48.13.475, upon written demand for a hearing
30 made by any person aggrieved by any act, threatened act, or failure of
31 the commissioner to act, if such failure is deemed an act under any
32 provision of this code, or by any report, promulgation, or order of the
33 commissioner other than an order on a hearing of which such person was
34 given actual notice or at which such person appeared as a party, or
35 order pursuant to the order on such hearing.

36 (2) Any such demand for a hearing shall specify in what respects

1 such person is so aggrieved and the grounds to be relied upon as basis
2 for the relief to be demanded at the hearing.

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

10 (4) If a hearing is demanded by a licensee whose license has been
11 temporarily suspended pursuant to RCW 48.17.540, the commissioner shall
12 hold such hearing demanded within thirty days after receipt of the
13 demand or within thirty days of the effective date of a temporary
14 license suspension issued after such demand, unless postponed by mutual
15 consent.

16 ~~((5) A licensee under this title may request that a hearing
17 authorized under this section be presided over by an administrative law
18 judge assigned under chapter 34.12 RCW. Any such request shall not be
19 denied.~~

20 ~~((6) Any hearing held relating to RCW 48.20.025, 48.44.017, or
21 48.46.062 shall be presided over by an administrative law judge
22 assigned under chapter 34.12 RCW.))~~

23 **Sec. 3.** RCW 48.18.110 and 2000 c 79 s 2 are each amended to read
24 as follows:

25 ~~((1))~~ The commissioner shall disapprove any such form of policy,
26 application, rider, or endorsement, or withdraw any previous approval
27 thereof, only:

28 ~~((a))~~ (1) If it is in any respect in violation of or does not
29 comply with this code or any applicable order or regulation of the
30 commissioner issued pursuant to the code; or

31 ~~((b))~~ (2) If it does not comply with any controlling filing
32 theretofore made and approved; or

33 ~~((c))~~ (3) If it contains or incorporates by reference any
34 inconsistent, ambiguous or misleading clauses, or exceptions and
35 conditions which unreasonably or deceptively affect the risk purported
36 to be assumed in the general coverage of the contract; or

1 ~~((d))~~ (4) If it has any title, heading, or other indication of
2 its provisions which is misleading; or
3 ~~((e))~~ (5) If purchase of insurance thereunder is being solicited
4 by deceptive advertising(~~(-~~
5 ~~(2) In addition to the grounds for disapproval of any such form as~~
6 ~~provided in subsection (1) of this section, the commissioner may~~
7 ~~disapprove any form of disability insurance policy, except an~~
8 ~~individual health benefit plan,))); or
9 (6) If the benefits provided therein are unreasonable in relation
10 to the premium charged.~~

11 **Sec. 4.** RCW 48.20.025 and 2003 c 248 s 8 are each amended to read
12 as follows:

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

15 (a) "Claims" means the cost to the insurer of health care services,
16 as defined in RCW 48.43.005, provided to a policyholder or paid to or
17 on behalf of the policyholder in accordance with the terms of a health
18 benefit plan, as defined in RCW 48.43.005. This includes capitation
19 payments or other similar payments made to providers for the purpose of
20 paying for health care services for a policyholder.

21 (b) "Claims reserves" means: (i) The liability for claims which
22 have been reported but not paid; (ii) the liability for claims which
23 have not been reported but which may reasonably be expected; (iii)
24 active life reserves; and (iv) additional claims reserves whether for
25 a specific liability purpose or not.

26 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,
27 plus any rate credits or recoupments less any refunds, for the
28 applicable period, whether received before, during, or after the
29 applicable period.

30 (d) "Incurred claims expense" means claims paid during the
31 applicable period plus any increase, or less any decrease, in the
32 claims reserves.

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

35 (f) "Reserves" means: (i) Active life reserves; and (ii)
36 additional reserves whether for a specific liability purpose or not.

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

4 (3) An insurer shall file with the notice required under subsection
5 (2) of this section supporting documentation of its method of
6 determining the rates charged. The commissioner may request (~~only the~~
7 ~~following~~) supporting documentation, including but not limited to:

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

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

12 (c) The percentage of premium attributable in aggregate for
13 nonclaims expenses used to determine the adjusted community rates
14 charged; and

15 (d) A certification by (~~(a)~~) an independent member of the American
16 academy of actuaries, or other person approved by the commissioner,
17 that the adjusted community rate charged can be reasonably expected to
18 result in a loss ratio that meets or exceeds the loss ratio standard
19 established in subsection (~~(+7)~~) (6) of this section.

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

22 ~~(+5)~~) By the last day of May each year any insurer issuing or
23 renewing individual health benefit plans in this state during the
24 preceding calendar year shall file for review by the commissioner
25 supporting documentation of its actual loss ratio for its individual
26 health benefit plans offered or renewed in the state in aggregate for
27 the preceding calendar year. The filing shall include aggregate earned
28 premiums, aggregate incurred claims, and a certification by (~~(a)~~) an
29 independent member of the American academy of actuaries, or other
30 person approved by the commissioner, that the actual loss ratio has
31 been calculated in accordance with accepted actuarial principles.

32 (a) At the expiration of a thirty-day period beginning with the
33 date the filing is received by the commissioner, the filing shall be
34 deemed approved unless prior thereto the commissioner contests the
35 calculation of the actual loss ratio.

36 (b) If the commissioner contests the calculation of the actual loss
37 ratio, the commissioner shall state in writing the grounds for
38 contesting the calculation to the insurer.

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

4 ~~((+6))~~ (5) If the actual loss ratio for the preceding calendar
5 year is less than the loss ratio established in subsection ~~((+7))~~ (6)
6 of this section, a remittance is due and the following shall apply:

7 (a) The insurer shall calculate a percentage of premium to be
8 remitted to the Washington state health insurance pool by subtracting
9 the actual loss ratio for the preceding year from the loss ratio
10 established in subsection ~~((+7))~~ (6) of this section.

11 (b) The remittance to the Washington state health insurance pool is
12 the percentage calculated in (a) of this subsection, multiplied by the
13 premium earned from each enrollee in the previous calendar year.
14 Interest shall be added to the remittance due at a five percent annual
15 rate calculated from the end of the calendar year for which the
16 remittance is due to the date the remittance is made.

17 (c) All remittances shall be aggregated and such amounts shall be
18 remitted to the Washington state high risk pool to be used ~~((as~~
19 ~~directed by the pool board of directors))~~ solely to fund the rate
20 discounts provided under RCW 48.41.200.

21 (d) Any remittance required to be issued under this section shall
22 be issued within thirty days after the actual loss ratio is deemed
23 approved under subsection ~~((+5))~~ (4)(a) of this section or the
24 determination by an administrative law judge under subsection ~~((+5))~~
25 (4)(c) of this section.

26 ~~((+7))~~ (6) The loss ratio applicable to this section shall be
27 ~~((seventy-four))~~ eighty-three percent minus the premium tax rate
28 applicable to the insurer's individual health benefit plans under RCW
29 48.14.020.

30 **Sec. 5.** RCW 48.41.030 and 2004 c 260 s 25 are each amended to read
31 as follows:

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

34 (1) "Accounting year" means a twelve-month period determined by the
35 board for purposes of record-keeping and accounting. The first
36 accounting year may be more or less than twelve months and, from time

1 to time in subsequent years, the board may order an accounting year of
2 other than twelve months as may be required for orderly management and
3 accounting of the pool.

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

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

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

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

11 (6) "Health care facility" has the same meaning as in RCW
12 70.38.025.

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

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

18 (9) "Health carrier" or "carrier" has the same meaning as in RCW
19 48.43.005.

20 (10) "Health coverage" means any group or individual disability
21 insurance policy, health care service contract, and health maintenance
22 agreement, including medicare supplemental policies, except those
23 contracts entered into for the provision of health care services
24 pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395
25 et seq. The term does not include short-term care, long-term care,
26 dental, vision, accident, fixed indemnity, disability income contracts,
27 limited benefit or credit insurance, coverage issued as a supplement to
28 liability insurance, insurance arising out of the worker's compensation
29 or similar law, automobile medical payment insurance, or insurance
30 under which benefits are payable with or without regard to fault and
31 which is statutorily required to be contained in any liability
32 insurance policy or equivalent self-insurance.

33 (11) "Health plan" means any arrangement by which persons,
34 including dependents or spouses, covered or making application to be
35 covered under this pool, have access to hospital and medical benefits
36 or reimbursement including any group or individual disability insurance
37 policy; health care service contract; health maintenance agreement;
38 uninsured arrangements of group or group-type contracts including

1 employer self-insured, cost-plus, or other benefit methodologies not
2 involving insurance or not governed by Title 48 RCW; coverage under
3 group-type contracts which are not available to the general public and
4 can be obtained only because of connection with a particular
5 organization or group; and coverage by medicare or other governmental
6 benefits. This term includes coverage through "health coverage" as
7 defined under this section, and specifically excludes those types of
8 programs excluded under the definition of "health coverage" in
9 subsection (10) of this section.

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

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

15 (14) "Member" means any commercial insurer which provides
16 disability insurance or stop loss insurance, any health care service
17 contractor, any health maintenance organization licensed under Title 48
18 RCW, and any self-funded multiple employer welfare arrangement as
19 defined in RCW 48.125.010. "Member" also means the Washington state
20 health care authority as issuer of the state uniform medical plan.
21 "Member" shall also mean, (~~as soon as~~) to the extent authorized by
22 federal law, employers and other entities, including a self-funding
23 entity and employee welfare benefit plans that provide health plan
24 benefits in this state on or after May 18, 1987. "Member" does not
25 include any insurer, health care service contractor, or health
26 maintenance organization whose products are exclusively dental products
27 or those products excluded from the definition of "health coverage" set
28 forth in subsection (10) of this section.

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

34 (16) "Plan of operation" means the pool, including articles, by-
35 laws, and operating rules, adopted by the board pursuant to RCW
36 48.41.050.

37 (17) "Point of service plan" means a benefit plan offered by the

1 pool under which a covered person may elect to receive covered services
2 from network providers, or nonnetwork providers at a reduced rate of
3 benefits.

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

6 **Sec. 6.** RCW 48.41.037 and 2000 c 79 s 36 are each amended to read
7 as follows:

8 The Washington state health insurance pool account is created in
9 the custody of the state treasurer. All receipts from moneys
10 specifically appropriated to the account must be deposited in the
11 account. Expenditures from this account shall be used to cover
12 deficits incurred by the Washington state health insurance pool under
13 this chapter in excess of the threshold established in this section.
14 To the extent funds are available in the account, funds shall be
15 expended from the account to offset that portion of the deficit that
16 would otherwise have to be recovered by imposing an assessment on
17 members in excess of a threshold of (~~seventy~~) one dollar and fifty
18 cents per insured person per month for the calendar year 2005, and
19 indexed annually thereafter to the rate of medical inflation as
20 determined by the office of financial management. The commissioner
21 shall authorize expenditures from the account, to the extent that funds
22 are available in the account, upon actuarial certification to the
23 commissioner by the pool board that assessments (~~will~~) for the
24 current calendar year are expected to exceed the threshold level
25 established in this section. The certification shall be sent to the
26 commissioner no later than September 30th of each year. The account is
27 subject to the allotment procedures under chapter 43.88 RCW, but an
28 appropriation is not required for expenditures.

29 **Sec. 7.** RCW 48.41.040 and 2000 c 80 s 1 are each amended to read
30 as follows:

31 (1) There is created a nonprofit entity to be known as the
32 Washington state health insurance pool. All members in this state on
33 or after May 18, 1987, shall be members of the pool. When authorized
34 by federal law, all self-insured employers shall also be members of the
35 pool.

1 (2) Pursuant to chapter 34.05 RCW the commissioner shall, within
2 ninety days after May 18, 1987, give notice to all members of the time
3 and place for the initial organizational meetings of the pool. A board
4 of directors shall be established, which shall be comprised of ten
5 members. The governor shall select one member of the board from each
6 list of three nominees submitted by statewide organizations
7 representing each of the following: (a) Health care providers; (b)
8 health insurance agents; (c) small employers; and (d) large employers.
9 The governor shall select (~~two~~) three members of the board from a
10 list of nominees submitted by statewide organizations representing
11 health care consumers. In making these selections, the governor may
12 request additional names from the statewide organizations representing
13 each of the persons to be selected if the governor chooses not to
14 select a member from the list submitted. The remaining (~~four~~) three
15 members of the board shall be selected by election from among the
16 members of the pool. The elected members shall, to the extent
17 possible, include at least one representative of health care service
18 contractors, one representative of health maintenance organizations,
19 and one representative of commercial insurers which provides disability
20 insurance. The members of the board shall elect a chair from the
21 voting members of the board. The insurance commissioner shall be a
22 nonvoting, ex officio member. When self-insured organizations other
23 than the Washington state health care authority become eligible for
24 participation in the pool, the membership of the board shall be
25 increased to eleven and at least one member of the board shall
26 represent the self-insurers.

27 (3) The original members of the board of directors shall be
28 appointed for intervals of one to three years. Thereafter, all board
29 members shall serve a term of three years. Board members shall receive
30 no compensation, but shall be reimbursed for all travel expenses as
31 provided in RCW 43.03.050 and 43.03.060.

32 (4) The board shall submit to the commissioner a plan of operation
33 for the pool and any amendments thereto necessary or suitable to assure
34 the fair, reasonable, and equitable administration of the pool. The
35 commissioner shall, after notice and hearing pursuant to chapter 34.05
36 RCW, approve the plan of operation if it is determined to assure the
37 fair, reasonable, and equitable administration of the pool and provides
38 for the sharing of pool losses on an equitable, proportionate basis

1 among the members of the pool. The plan of operation shall become
2 effective upon approval in writing by the commissioner consistent with
3 the date on which the coverage under this chapter must be made
4 available. If the board fails to submit a plan of operation within one
5 hundred eighty days after the appointment of the board or any time
6 thereafter fails to submit acceptable amendments to the plan, the
7 commissioner shall, within ninety days after notice and hearing
8 pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are
9 necessary or advisable to effectuate this chapter. The rules shall
10 continue in force until modified by the commissioner or superseded by
11 a plan submitted by the board and approved by the commissioner.

12 **Sec. 8.** RCW 48.41.060 and 2004 c 260 s 26 are each amended to read
13 as follows:

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

19 (a) Designate or establish the standard health questionnaire to be
20 used under RCW 48.41.100 and 48.43.018, including the form and content
21 of the standard health questionnaire and the method of its application.
22 The questionnaire must provide for an objective evaluation of an
23 individual's health status by assigning a discreet measure, such as a
24 system of point scoring to each individual. The questionnaire must not
25 contain any questions related to pregnancy, and pregnancy shall not be
26 a basis for coverage by the pool. The questionnaire shall be designed
27 such that it is reasonably expected to identify the (~~eight~~) five
28 percent of persons who are the most costly to treat who are under
29 individual coverage in health benefit plans, as defined in RCW
30 48.43.005, in Washington state or are covered by the pool, if applied
31 to all such persons;

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

35 (c) Approve the standard health questionnaire and any modifications
36 needed to comply with this chapter. The standard health questionnaire
37 shall be submitted to an actuary for certification, modified as

1 necessary, and approved at least every eighteen months. The
2 designation and approval of the standard health questionnaire by the
3 board shall ~~((not))~~ be subject to review and approval by the
4 commissioner. The standard health questionnaire or any modification
5 thereto shall not be used until ninety days after public notice of the
6 commissioner's approval of the questionnaire or any modification
7 thereto, except that the initial standard health questionnaire approved
8 for use by the board after March 23, 2000, may be used immediately
9 following public notice of such approval;

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

20 (e) Assess members of the pool in accordance with the provisions of
21 this chapter, and make advance interim assessments as may be reasonable
22 and necessary for the organizational or interim operating expenses.
23 Any interim assessments will be credited as offsets against any regular
24 assessments due following the close of the year. Self-funded multiple
25 employer welfare arrangements are subject to assessment under this
26 subsection only in the event that assessments are not preempted by the
27 employee retirement income security act of 1974, as amended, 29 U.S.C.
28 Sec. 1001 et seq. The arrangements and the commissioner shall
29 initially request an advisory opinion from the United States department
30 of labor or obtain a declaratory ruling from a federal court on the
31 legality of imposing assessments on these arrangements before imposing
32 the assessment. If there has not been a final determination by the
33 United States department of labor or a federal court that the
34 assessments are not preempted by federal law, the assessments provided
35 for in this subsection become effective on March 1, 2005, or thirty
36 days following the issuance of a certificate of authority, whichever is
37 later. During the time period between March 1, 2005, or thirty days
38 following the issuance of a certificate of authority, whichever is

1 later, and the final determination by the United States department of
2 labor or a federal court, any assessments shall be deposited in an
3 interest bearing escrow account maintained by the (~~(self-funded)~~)
4 self-funded multiple employer welfare arrangement. Upon a final
5 determination that the assessments are not preempted by the employee
6 retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001
7 et seq., all funds in the interest bearing escrow account shall be
8 transferred to the board;

9 (f) Issue policies of health coverage in accordance with the
10 requirements of this chapter;

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

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

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

19 (j) Provide certification to the commissioner when assessments will
20 exceed the threshold level established in RCW 48.41.037;

21 (k) Contract with an independent certified public accountant for an
22 annual audit of pool operations;

23 (l) Conduct, at least once every eighteen months, a statistically
24 valid survey of pool enrollees to determine their satisfaction with
25 coverage, rates, administration, and other customer service issues, and
26 report the results of the survey to the commissioner upon its
27 completion; and

28 (m) Conduct, at least once every eighteen months, a statistically
29 valid survey of individual market applicants who, through the use of
30 the standard health questionnaire, were referred to the pool by
31 carriers, with the intention to discern demographic information
32 including but not limited to the current coverage status of the
33 surveyed applicants whether or not they enrolled in a pool plan; their
34 understanding of the standard health questionnaire, its clarity and
35 ease of use; and their opinions regarding plan choices, premiums, and
36 barriers to entry into the pool. Results of the survey shall be
37 reported to the commissioner upon its completion.

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. 9.** RCW 48.41.080 and 2000 c 79 s 10 are each amended to read
21 as follows:

22 The board shall select an administrator through a competitive
23 bidding process to administer the pool.

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

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

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

28 (c) An estimate of the total charges for administering the plan;

29 and

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

32 (2) The administrator shall serve for a period of three years
33 subject to removal for cause by the pool board. At least six months
34 prior to the expiration of each three-year period of service by the
35 administrator, the board shall invite all interested parties, including
36 the current administrator, to submit bids to serve as the administrator

1 for the succeeding three-year period. Selection of the administrator
2 for this succeeding period shall be made at least three months prior to
3 the end of the current three-year period.

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

6 (a) Administering eligibility and administrative claim payment
7 functions relating to the pool;

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

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

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

17 (ii) Taking steps necessary to offer and administer managed care
18 benefit plans; and

19 (iii) Evaluating the eligibility of each claim for payment by the
20 pool;

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

24 (e) Following the close of each accounting year, determination of
25 net paid and earned premiums, the expense of administration, and the
26 paid and incurred losses for the year and reporting this information to
27 the board and the commissioner on a form as prescribed by the
28 commissioner; and

29 (f) Administering the premium discounts provided under RCW
30 48.41.200.

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

34 **Sec. 10.** RCW 48.41.090 and 2000 c 79 s 11 are each amended to read
35 as follows:

36 (1) Following the close of each accounting year, the pool
37 administrator shall determine the net premium (premiums less

1 administrative expense allowances), the pool expenses of
2 administration, and incurred losses for the year, taking into account
3 investment income and other appropriate gains and losses.

4 (2)(a) Each member's proportion of participation in the pool shall
5 be determined annually by the board based on annual statements and
6 other reports deemed necessary by the board and filed by the member
7 with the commissioner; and shall be determined by multiplying the total
8 cost of pool operation by a fraction. The numerator of the fraction
9 equals that member's total number of resident insured persons,
10 including spouse and dependents, covered under all health plans in the
11 state by that member during the preceding calendar year. The
12 denominator of the fraction equals the total number of resident insured
13 persons, including spouses and dependents, covered under all health
14 plans in the state by all pool members during the preceding calendar
15 year.

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

18 ~~(+))~~), all health plans in the state by the state health care
19 authority include only the uniform medical plan(~~(+ and~~

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

23 (c) Except as provided in RCW 48.41.037, any deficit incurred by
24 the pool shall be recouped by assessments among members apportioned
25 under this subsection pursuant to the formula set forth by the board
26 among members.

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

36 (4) If assessments exceed actual losses and administrative expenses
37 of the pool, the excess shall be held at interest and used by the board

1 to offset future losses or to reduce pool premiums. As used in this
2 subsection, "future losses" includes reserves for incurred but not
3 reported claims.

4 (5) A member's payment of the assessment shall not be the basis for
5 an exemption or deduction from any state taxes or fees.

6 **Sec. 11.** RCW 48.41.100 and 2001 c 196 s 3 are each amended to read
7 as follows:

8 (1) The following persons who are residents of this state are
9 eligible for pool coverage:

10 (a) Any person who provides evidence of a carrier's decision not to
11 accept him or her for enrollment in an individual health benefit plan
12 as defined in RCW 48.43.005 based upon, and within ninety days of the
13 receipt of, the results of the standard health questionnaire designated
14 by the board and administered by health carriers under RCW 48.43.018;

15 (b) Any person who continues to be eligible for pool coverage based
16 upon the results of the standard health questionnaire designated by the
17 board and administered by the pool administrator pursuant to subsection
18 (3) of this section;

19 (c) Any person who resides in a county of the state where no
20 carrier or insurer eligible under chapter 48.15 RCW offers to the
21 public an individual health benefit plan other than a catastrophic
22 health plan as defined in RCW 48.43.005 at the time of application to
23 the pool, and who makes direct application to the pool; (~~and~~)

24 (d) Any medicare eligible person upon providing evidence of
25 rejection for medical reasons for any policy for which he or she has
26 applied, a requirement of restrictive riders, an up-rated premium, or
27 a preexisting conditions limitation on a medicare supplemental
28 insurance policy under chapter 48.66 RCW, the effect of which is to
29 substantially reduce coverage from that received by a person considered
30 a standard risk by at least one member within six months of the date of
31 application; and

32 (e) Any person whom the United States social security
33 administration determines to be disabled.

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

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

1 show continuous other coverage which has been involuntarily terminated
2 for any reason other than nonpayment of premiums. However, these
3 exclusions do not apply to eligible individuals as defined in section
4 2741(b) of the federal health insurance portability and accountability
5 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

6 (b) Any person on whose behalf the pool has paid out one million
7 dollars in benefits;

8 (c) Inmates of public institutions and persons whose medical,
9 hospital, and prescription drug benefits are duplicated under public
10 programs. However, these exclusions do not apply to eligible
11 individuals as defined in section 2741(b) of the federal health
12 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
13 300gg-41(b));

14 (d) Any person who resides in a county of the state where any
15 carrier or insurer regulated under chapter 48.15 RCW offers to the
16 public an individual health benefit plan other than a catastrophic
17 health plan as defined in RCW 48.43.005 at the time of application to
18 the pool and who does not qualify for pool coverage based upon the
19 results of the standard health questionnaire, or pursuant to subsection
20 (1)(d) of this section.

21 (3) When a carrier or insurer regulated under chapter 48.15 RCW
22 begins to offer an individual health benefit plan in a county where no
23 carrier had been offering an individual health benefit plan:

24 (a) If the health benefit plan offered is other than a catastrophic
25 health plan as defined in RCW 48.43.005, any person enrolled in a pool
26 plan pursuant to subsection (1)(c) of this section in that county shall
27 no longer be eligible for coverage under that plan pursuant to
28 subsection (1)(c) of this section, but may continue to be eligible for
29 pool coverage based upon the results of the standard health
30 questionnaire designated by the board and administered by the pool
31 administrator. The pool administrator shall offer to administer the
32 questionnaire to each person no longer eligible for coverage under
33 subsection (1)(c) of this section within thirty days of determining
34 that he or she is no longer eligible;

35 (b) Losing eligibility for pool coverage under this subsection (3)
36 does not affect a person's eligibility for pool coverage under
37 subsection (1)(a), (b), or (d) of this section; and

1 (c) The pool administrator shall provide written notice to any
2 person who is no longer eligible for coverage under a pool plan under
3 this subsection (3) within thirty days of the administrator's
4 determination that the person is no longer eligible. The notice shall:
5 (i) Indicate that coverage under the plan will cease ninety days from
6 the date that the notice is dated; (ii) describe any other coverage
7 options, either in or outside of the pool, available to the person;
8 (iii) describe the procedures for the administration of the standard
9 health questionnaire to determine the person's continued eligibility
10 for coverage under subsection (1)(b) of this section; and (iv) describe
11 the enrollment process for the available options outside of the pool.

12 **Sec. 12.** RCW 48.41.110 and 2001 c 196 s 4 are each amended to read
13 as follows:

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

22 (2) The administrator shall prepare ~~((a brochure))~~ brochures and
23 other informational material outlining the benefits and exclusions of
24 the pool policy in plain language. After approval by the board, such
25 ~~((brochure))~~ material shall be made reasonably available to
26 participants or potential participants.

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

35 (a) Hospital services ~~((, including charges for the most common~~
36 ~~semiprivate room, for the most common private room if semiprivate rooms~~
37 ~~do not exist in the health care facility, or for the private room if~~

1 ~~medically necessary, but limited to a total of one hundred eighty~~
2 ~~inpatient days in a calendar year, and limited to thirty days inpatient~~
3 ~~care for mental and nervous conditions, or alcohol, drug, or chemical~~
4 ~~dependency or abuse per calendar year));~~

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

10 (c) (~~The first twenty~~) Inpatient and outpatient professional
11 visits for the diagnosis or treatment of (~~one or more~~) mental or
12 nervous conditions or alcohol, drug, or chemical dependency or abuse
13 rendered (~~during a calendar year~~) by one or more physicians,
14 psychologists, or community mental health professionals, or, at the
15 direction of a physician, by other qualified licensed health care
16 practitioners, in the case of mental or nervous conditions, and
17 rendered by a state certified chemical dependency program approved
18 under chapter 70.96A RCW, in the case of alcohol, drug, or chemical
19 dependency or abuse;

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

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

24 (f) Services of a home health agency;

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

27 (h) Oxygen;

28 (i) Anesthesia services;

29 (j) Prostheses, other than dental;

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

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

33 (m) Oral surgery limited to the following: Fractures of facial
34 bones; excisions of mandibular joints, lesions of the mouth, lip, or
35 tongue, tumors, or cysts excluding treatment for temporomandibular
36 joints; incision of accessory sinuses, mouth salivary glands or ducts;
37 dislocations of the jaw; plastic reconstruction or repair of traumatic

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

3 (n) Maternity care services;

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

6 (p) Hospice services;

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

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

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

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

26 (6) The pool may not reject an individual for health plan coverage
27 based upon preexisting conditions of the individual or deny, exclude,
28 or otherwise limit coverage for an individual's preexisting health
29 conditions; except that it shall impose a (~~(six)~~) three-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 for the formula necessary for the treatment of
36 phenylketonuria. The pool may not avoid the requirements of this
37 section through the creation of a new rate classification or the

1 modification of an existing rate classification. Credit against the
2 waiting period shall be as provided in subsection (7) of this section.

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

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

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

25 **Sec. 13.** RCW 48.41.120 and 2000 c 79 s 14 are each amended to read
26 as follows:

27 (1) Subject to the limitation provided in subsection (3) of this
28 section, a pool policy offered in accordance with RCW 48.41.110(3)
29 shall impose a deductible. Deductibles of five hundred dollars and one
30 thousand dollars on a per person per calendar year basis shall
31 initially be offered. The board may authorize deductibles in other
32 amounts. The deductible shall be applied to the first (~~five hundred~~
33 ~~dollars, one thousand dollars, or other authorized~~) amount of eligible
34 expenses incurred by the covered person.

35 (2) Subject to the limitations provided in subsection (3) of this
36 section, a mandatory coinsurance requirement shall be imposed at the

1 rate of twenty percent of eligible expenses in excess of the mandatory
2 deductible.

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

7 (a) One thousand five hundred dollars per individual, or three
8 thousand dollars per family, per calendar year for the five hundred
9 dollar deductible policy;

10 (b) Two thousand five hundred dollars per individual, or five
11 thousand dollars per family per calendar year for the one thousand
12 dollar deductible policy; or

13 (c) An amount authorized by the board for any other deductible
14 policy.

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

18 **Sec. 14.** RCW 48.41.140 and 2000 c 79 s 16 are each amended to read
19 as follows:

20 (1) Coverage shall provide that health insurance benefits are
21 applicable to children of the person in whose name the policy is issued
22 including adopted and newly born natural children. Coverage shall also
23 include necessary care and treatment of medically diagnosed congenital
24 (~~defects~~) disorders and birth abnormalities. If payment of a
25 specific premium is required to provide coverage for the child, the
26 policy may require that notification of the birth or adoption of a
27 child and payment of the required premium must be furnished to the pool
28 within thirty-one days after the date of birth or adoption in order to
29 have the coverage continued beyond the thirty-one day period. For
30 purposes of this subsection, a child is deemed to be adopted, and
31 benefits are payable, when the child is physically placed for purposes
32 of adoption under the laws of this state with the person in whose name
33 the policy is issued; and, when the person in whose name the policy is
34 issued assumes financial responsibility for the medical expenses of the
35 child. For purposes of this subsection, "newly born" means, and
36 benefits are payable, from the moment of birth.

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

13 **Sec. 15.** RCW 48.41.160 and 1987 c 431 s 16 are each amended to
14 read as follows:

15 (1) A pool policy offered under this chapter shall contain
16 provisions under which the pool is obligated to renew the policy until
17 the day on which the individual in whose name the policy is issued
18 first becomes eligible for medicare coverage. At that time, coverage
19 of dependents shall terminate if such dependents are eligible for
20 coverage under a different health plan. Dependents who become eligible
21 for medicare prior to the individual in whose name the policy is
22 issued, shall receive benefits in accordance with RCW 48.41.150.

23 (2) The pool may not change the rates for pool policies except on
24 a class basis, with a clear disclosure in the policy of the pool's
25 right to do so.

26 (3) A pool policy offered under this chapter shall provide that,
27 upon the death of the individual in whose name the policy is issued,
28 every other individual then covered under the policy may elect, within
29 a period specified in the policy, to continue coverage under the same
30 or a different policy.

31 (4) At least once a year, the pool must provide the opportunity for
32 any person covered by a pool policy, other than the medicare
33 supplemental policy, to change coverage to any other pool policy, other
34 than the medicare supplemental policy.

35 **Sec. 16.** RCW 48.41.190 and 1989 c 121 s 10 are each amended to
36 read as follows:

1 (~~Neither the participation by members, the establishment of rates,~~
2 ~~forms, or procedures for coverages issued by the pool, nor any other~~
3 ~~joint or collective action required by this chapter or the state of~~
4 ~~Washington shall be the basis of any legal action, civil or criminal~~
5 ~~liability or penalty against the pool, any member of the board of~~
6 ~~directors, or members of the pool either jointly or separately.)) The
7 pool, members of the pool, board directors of the pool, officers of the
8 pool, employees of the pool, the commissioner, the commissioner's
9 representatives, and the commissioner's employees shall not be civilly
10 or criminally liable and shall not have any penalty or cause of action
11 of any nature arise against them for any action taken or not taken,
12 including any discretionary decision or failure to make a discretionary
13 decision, when the action or inaction is done in good faith and in the
14 performance of the powers and duties under this chapter.~~

15 **Sec. 17.** RCW 48.41.200 and 2000 c 79 s 17 are each amended to read
16 as follows:

17 (1) The pool shall determine the standard risk rate by calculating
18 the average individual standard rate charged for coverage comparable to
19 pool coverage by the five largest members, measured in terms of average
20 individual market enrollment during the previous two calendar years,
21 offering such coverages in the state. In the event five members do not
22 offer comparable coverage, the standard risk rate shall be established
23 using reasonable actuarial techniques and shall reflect anticipated
24 experience and expenses for such coverage where it is currently
25 available in the individual market.

26 (2) Subject to subsection (3) of this section, maximum rates for
27 pool coverage shall be as follows:

28 (a) Maximum rates for a pool indemnity health plan shall be one
29 hundred fifty percent of the rate calculated under subsection (1) of
30 this section;

31 (b) Maximum rates for a pool care management plan shall be one
32 hundred twenty-five percent of the rate calculated under subsection (1)
33 of this section; (~~and~~)

34 (c) Maximum rates for a person under age sixty-five covered by the
35 pool medicare supplemental policy shall be one hundred ten percent of
36 the rate calculated under subsection (1) of this section; and

1 (d) Maximum rates for a person eligible for pool coverage pursuant
2 to RCW 48.41.100(1)(a) who was enrolled at any time during the sixty-
3 three day period immediately prior to the date of application for pool
4 coverage in a group health benefit plan or an individual health benefit
5 plan other than a catastrophic health plan as defined in RCW 48.43.005,
6 where such coverage was continuous for at least eighteen months, shall
7 be:

8 (i) For a pool indemnity health plan, one hundred twenty-five
9 percent of the rate calculated under subsection (1) of this section;
10 and

11 (ii) For a pool care management plan, one hundred ten percent of
12 the rate calculated under subsection (1) of this section.

13 (3)(a) Subject to (b) and (c) of this subsection:

14 (i) The rate for any person (~~((aged fifty to sixty four))~~) whose
15 current gross family income is less than two hundred fifty-one percent
16 of the federal poverty level shall be reduced by (~~((thirty))~~) fifty-five
17 percent from what it would otherwise be;

18 (ii) The rate for any person (~~((aged fifty to sixty four))~~) whose
19 current gross family income is more than two hundred fifty but less
20 than three hundred one percent of the federal poverty level shall be
21 reduced by fifteen percent from what it would otherwise be;

22 (iii) The rate for any person who has been enrolled in the pool for
23 more than thirty-six months shall be reduced by five percent from what
24 it would otherwise be.

25 (b) In no event shall the rate for any person, except those
26 eligible for a rate reduction under (a)(i) of this subsection, be less
27 than one hundred ten percent of the rate calculated under subsection
28 (1) of this section.

29 (c) Rate reductions under (a)(i) and (ii) of this subsection shall
30 be available only to the extent that funds are specifically
31 appropriated for this purpose in the omnibus appropriations act or to
32 the extent funds are available from remittance due under RCW
33 48.20.025(5)(c), 48.44.017(5)(c), or 48.46.062(5)(c).

34 **Sec. 18.** RCW 48.44.017 and 2001 c 196 s 11 are each amended to
35 read as follows:

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

1 (a) "Claims" means the cost to the health care service contractor
2 of health care services, as defined in RCW 48.43.005, provided to a
3 contract holder or paid to or on behalf of a contract holder in
4 accordance with the terms of a health benefit plan, as defined in RCW
5 48.43.005. This includes capitation payments or other similar payments
6 made to providers for the purpose of paying for health care services
7 for an enrollee.

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

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

17 (d) "Incurred claims expense" means claims paid during the
18 applicable period plus any increase, or less any decrease, in the
19 claims reserves.

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

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

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

27 (3) A health care service contractor shall file with the notice
28 required under subsection (2) of this section supporting documentation
29 of its method of determining the rates charged. The commissioner may
30 request (~~(only the following)~~) supporting documentation, including but
31 not limited to:

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

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

37 (c) The percentage of premium attributable in aggregate for

1 nonclaims expenses used to determine the adjusted community rates
2 charged; and

3 (d) A certification by ((a)) an independent member of the American
4 academy of actuaries, or other person approved by the commissioner,
5 that the adjusted community rate charged can be reasonably expected to
6 result in a loss ratio that meets or exceeds the loss ratio standard
7 established in subsection ((+7)) (6) of this section.

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

10 ~~(+5))~~ By the last day of May each year any health care service
11 contractor issuing or renewing individual health benefit plans in this
12 state during the preceding calendar year shall file for review by the
13 commissioner supporting documentation of its actual loss ratio for its
14 individual health benefit plans offered or renewed in this state in
15 aggregate for the preceding calendar year. The filing shall include
16 aggregate earned premiums, aggregate incurred claims, and ((a)) an
17 independent certification by a member of the American academy of
18 actuaries, or other person approved by the commissioner, that the
19 actual loss ratio has been calculated in accordance with accepted
20 actuarial principles.

21 (a) At the expiration of a thirty-day period beginning with the
22 date the filing is received by the commissioner, the filing shall be
23 deemed approved unless prior thereto the commissioner contests the
24 calculation of the actual loss ratio.

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

28 (c) Any dispute regarding the calculation of the actual loss ratio
29 shall upon written demand of either the commissioner or the health care
30 service contractor be submitted to hearing under chapters 48.04 and
31 34.05 RCW.

32 ~~((+6))~~ (5) If the actual loss ratio for the preceding calendar
33 year is less than the loss ratio standard established in subsection
34 ~~((+7))~~ (6) of this section, a remittance is due and the following
35 shall apply:

36 (a) The health care service contractor shall calculate a percentage
37 of premium to be remitted to the Washington state health insurance pool

1 by subtracting the actual loss ratio for the preceding year from the
2 loss ratio established in subsection ~~((+7))~~ (6) of this section.

3 (b) The remittance to the Washington state health insurance pool is
4 the percentage calculated in (a) of this subsection, multiplied by the
5 premium earned from each enrollee in the previous calendar year.
6 Interest shall be added to the remittance due at a five percent annual
7 rate calculated from the end of the calendar year for which the
8 remittance is due to the date the remittance is made.

9 (c) All remittances shall be aggregated and such amounts shall be
10 remitted to the Washington state high risk pool to be used ~~((as
11 directed by the pool board of directors))~~ solely to fund the rate
12 discounts provided under RCW 48.41.200.

13 (d) Any remittance required to be issued under this section shall
14 be issued within thirty days after the actual loss ratio is deemed
15 approved under subsection ~~((+5))~~ (4)(a) of this section or the
16 determination by an administrative law judge under subsection ~~((+5))~~
17 (4)(c) of this section.

18 ~~((+7))~~ (6) The loss ratio applicable to this section shall be
19 ~~((seventy-four))~~ eighty-three percent minus the premium tax rate
20 applicable to the health care service contractor's individual health
21 benefit plans under RCW 48.14.0201.

22 **Sec. 19.** RCW 48.44.020 and 2000 c 79 s 28 are each amended to read
23 as follows:

24 (1) Any health care service contractor may enter into contracts
25 with or for the benefit of persons or groups of persons which require
26 prepayment for health care services by or for such persons in
27 consideration of such health care service contractor providing one or
28 more health care services to such persons and such activity shall not
29 be subject to the laws relating to insurance if the health care
30 services are rendered by the health care service contractor or by a
31 participating provider.

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

36 (a) If it contains or incorporates by reference any inconsistent,

1 ambiguous or misleading clauses, or exceptions and conditions which
2 unreasonably or deceptively affect the risk purported to be assumed in
3 the general coverage of the contract; or

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

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

8 (d) If it contains unreasonable restrictions on the treatment of
9 patients; or

10 (e) If it violates any provision of this chapter; or

11 (f) If it fails to conform to minimum provisions or standards
12 required by regulation made by the commissioner pursuant to chapter
13 34.05 RCW; or

14 (g) If any contract for health care services with any state agency,
15 division, subdivision, board, or commission or with any political
16 subdivision, municipal corporation, or quasi-municipal corporation
17 fails to comply with state law(~~(-~~

18 ~~(3) In addition to the grounds listed in subsection (2) of this~~
19 ~~section, the commissioner may disapprove any group contract)); or~~

20 (h) If the benefits provided therein are unreasonable in relation
21 to the amount charged for the contract.

22 ~~((4))~~ (3)(a) Every contract between a health care service
23 contractor and a participating provider of health care services shall
24 be in writing and shall state that in the event the health care service
25 contractor fails to pay for health care services as provided in the
26 contract, the enrolled participant shall not be liable to the provider
27 for sums owed by the health care service contractor. Every such
28 contract shall provide that this requirement shall survive termination
29 of the contract.

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

33 **Sec. 20.** RCW 48.46.060 and 2000 c 79 s 31 are each amended to read
34 as follows:

35 (1) Any health maintenance organization may enter into agreements
36 with or for the benefit of persons or groups of persons, which require
37 prepayment for health care services by or for such persons in

1 consideration of the health maintenance organization providing health
2 care services to such persons. Such activity is not subject to the
3 laws relating to insurance if the health care services are rendered
4 directly by the health maintenance organization or by any provider
5 which has a contract or other arrangement with the health maintenance
6 organization to render health services to enrolled participants.

7 (2) All forms of health maintenance agreements issued by the
8 organization to enrolled participants or other marketing documents
9 purporting to describe the organization's comprehensive health care
10 services shall comply with such minimum standards as the commissioner
11 deems reasonable and necessary in order to carry out the purposes and
12 provisions of this chapter, and which fully inform enrolled
13 participants of the health care services to which they are entitled,
14 including any limitations or exclusions thereof, and such other rights,
15 responsibilities and duties required of the contracting health
16 maintenance organization.

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

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

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

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

29 (d) If it contains unreasonable restrictions on the treatment of
30 patients;

31 (e) If it is in any respect in violation of this chapter or if it
32 fails to conform to minimum provisions or standards required by the
33 commissioner by rule under chapter 34.05 RCW; or

34 (f) If any agreement for health care services with any state
35 agency, division, subdivision, board, or commission or with any
36 political subdivision, municipal corporation, or quasi-municipal
37 corporation fails to comply with state law((-

1 ~~(4) In addition to the grounds listed in subsection (2) of this~~
2 ~~section, the commissioner may disapprove any group agreement)); or~~

3 (g) If the benefits provided therein are unreasonable in relation
4 to the amount charged for the agreement.

5 ~~((+5))~~ (4) No health maintenance organization authorized under
6 this chapter shall cancel or fail to renew the enrollment on any basis
7 of an enrolled participant or refuse to transfer an enrolled
8 participant from a group to an individual basis for reasons relating
9 solely to age, sex, race, or health status. Nothing contained herein
10 shall prevent cancellation of an agreement with enrolled participants
11 (a) who violate any published policies of the organization which have
12 been approved by the commissioner, or (b) who are entitled to become
13 eligible for medicare benefits and fail to enroll for a medicare
14 supplement plan offered by the health maintenance organization and
15 approved by the commissioner, or (c) for failure of such enrolled
16 participant to pay the approved charge, including cost-sharing,
17 required under such contract, or (d) for a material breach of the
18 health maintenance agreement.

19 ~~((+6))~~ (5) No agreement form or amendment to an approved agreement
20 form shall be used unless it is first filed with the commissioner.

21 **Sec. 21.** RCW 48.46.062 and 2001 c 196 s 12 are each amended to
22 read as follows:

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

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

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

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

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

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

10 (f) "Reserves" means: (i) Active life reserves; and (ii)
11 additional reserves whether for a specific liability purpose or not.

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

15 (3) A health maintenance organization shall file with the notice
16 required under subsection (2) of this section supporting documentation
17 of its method of determining the rates charged. The commissioner may
18 request (~~(only the following)~~) supporting documentation, including but
19 not limited to:

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

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

25 (c) The percentage of premium attributable in aggregate for
26 nonclaims expenses used to determine the adjusted community rates
27 charged; and

28 (d) A certification by (~~(a)~~) an independent member of the American
29 academy of actuaries, or other person approved by the commissioner,
30 that the adjusted community rate charged can be reasonably expected to
31 result in a loss ratio that meets or exceeds the loss ratio standard
32 established in subsection (~~(+7)~~) (6) of this section.

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

35 ~~(5))~~) By the last day of May each year any health maintenance
36 organization issuing or renewing individual health benefit plans in
37 this state during the preceding calendar year shall file for review by
38 the commissioner supporting documentation of its actual loss ratio for

1 its individual health benefit plans offered or renewed in the state in
2 aggregate for the preceding calendar year. The filing shall include
3 aggregate earned premiums, aggregate incurred claims, and a
4 certification by a member of the American academy of actuaries, or
5 other person approved by the commissioner, that the actual loss ratio
6 has been calculated in accordance with accepted actuarial principles.

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

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

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

18 ~~((+6+))~~ (5) If the actual loss ratio for the preceding calendar
19 year is less than the loss ratio standard established in subsection
20 ~~((+7+))~~ (6) of this section, a remittance is due and the following
21 shall apply:

22 (a) The health maintenance organization shall calculate a
23 percentage of premium to be remitted to the Washington state health
24 insurance pool by subtracting the actual loss ratio for the preceding
25 year from the loss ratio established in subsection ~~((+7+))~~ (6) of this
26 section.

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

33 (c) All remittances shall be aggregated and such amounts shall be
34 remitted to the Washington state high risk pool to be used ~~((as
35 directed by the pool board of directors))~~ solely to fund the rate
36 discounts provided under RCW 48.41.200.

37 (d) Any remittance required to be issued under this section shall
38 be issued within thirty days after the actual loss ratio is deemed

1 approved under subsection (~~(+5+)~~) (4)(a) of this section or the
2 determination by an administrative law judge under subsection (~~(+5+)~~)
3 (4)(c) of this section.

4 (~~(+7+)~~) (6) The loss ratio applicable to this section shall be
5 (~~(seventy-four)~~) eighty-three percent minus the premium tax rate
6 applicable to the health maintenance organization's individual health
7 benefit plans under RCW 48.14.0201.

8 **Sec. 22.** RCW 70.47.060 and 2004 c 192 s 3 are each amended to read
9 as follows:

10 The administrator has the following powers and duties:

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

1 services, the administrator shall consider the guidelines for assessing
2 health services under the mandated benefits act of 1984, RCW 48.47.030,
3 and such other factors as the administrator deems appropriate.

4 (2)(a) To design and implement a structure of periodic premiums due
5 the administrator from subsidized enrollees that is based upon gross
6 family income, giving appropriate consideration to family size and the
7 ages of all family members. The enrollment of children shall not
8 require the enrollment of their parent or parents who are eligible for
9 the plan. The structure of periodic premiums shall be applied to
10 subsidized enrollees entering the plan as individuals pursuant to
11 subsection (11) of this section and to the share of the cost of the
12 plan due from subsidized enrollees entering the plan as employees
13 pursuant to subsection (12) of this section.

14 (b) To determine the periodic premiums due the administrator from
15 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
16 shall be in an amount equal to the cost charged by the managed health
17 care system provider to the state for the plan plus the administrative
18 cost of providing the plan to those enrollees and the premium tax under
19 RCW 48.14.0201.

20 (c) To determine the periodic premiums due the administrator from
21 health coverage tax credit eligible enrollees. Premiums due from
22 health coverage tax credit eligible enrollees must be in an amount
23 equal to the cost charged by the managed health care system provider to
24 the state for the plan, plus the administrative cost of providing the
25 plan to those enrollees and the premium tax under RCW 48.14.0201. The
26 administrator will consider the impact of eligibility determination by
27 the appropriate federal agency designated by the Trade Act of 2002
28 (P.L. 107-210) as well as the premium collection and remittance
29 activities by the United States internal revenue service when
30 determining the administrative cost charged for health coverage tax
31 credit eligible enrollees.

32 (d) An employer or other financial sponsor may, with the prior
33 approval of the administrator, pay the premium, rate, or any other
34 amount on behalf of a subsidized or nonsubsidized enrollee, by
35 arrangement with the enrollee and through a mechanism acceptable to the
36 administrator. The administrator shall establish a mechanism for
37 receiving premium payments from the United States internal revenue
38 service for health coverage tax credit eligible enrollees.

1 (e) To develop, as an offering by every health carrier providing
2 coverage identical to the basic health plan, as configured on January
3 1, 2001, a basic health plan model plan with uniformity in enrollee
4 cost-sharing requirements.

5 (3) To evaluate, with the cooperation of participating managed
6 health care system providers, the impact on the basic health plan of
7 enrolling health coverage tax credit eligible enrollees. The
8 administrator shall issue to the appropriate committees of the
9 legislature preliminary evaluations on June 1, 2005, and January 1,
10 2006, and a final evaluation by June 1, 2006. The evaluation shall
11 address the number of persons enrolled, the duration of their
12 enrollment, their utilization of covered services relative to other
13 basic health plan enrollees, and the extent to which their enrollment
14 contributed to any change in the cost of the basic health plan.

15 (4) To end the participation of health coverage tax credit eligible
16 enrollees in the basic health plan if the federal government reduces or
17 terminates premium payments on their behalf through the United States
18 internal revenue service.

19 (5) To design and implement a structure of enrollee cost-sharing
20 due a managed health care system from subsidized, nonsubsidized, and
21 health coverage tax credit eligible enrollees. The structure shall
22 discourage inappropriate enrollee utilization of health care services,
23 and may utilize copayments, deductibles, and other cost-sharing
24 mechanisms, but shall not be so costly to enrollees as to constitute a
25 barrier to appropriate utilization of necessary health care services.

26 (6) To limit enrollment of persons who qualify for subsidies so as
27 to prevent an overexpenditure of appropriations for such purposes.
28 Whenever the administrator finds that there is danger of such an
29 overexpenditure, the administrator shall close enrollment until the
30 administrator finds the danger no longer exists. Such a closure does
31 not apply to health coverage tax credit eligible enrollees who receive
32 a premium subsidy from the United States internal revenue service as
33 long as the enrollees qualify for the health coverage tax credit
34 program.

35 (7) To limit the payment of subsidies to subsidized enrollees, as
36 defined in RCW 70.47.020. The level of subsidy provided to persons who
37 qualify may be based on the lowest cost plans, as defined by the
38 administrator.

1 (8) To adopt a schedule for the orderly development of the delivery
2 of services and availability of the plan to residents of the state,
3 subject to the limitations contained in RCW 70.47.080 or any act
4 appropriating funds for the plan.

5 (9) To solicit and accept applications from managed health care
6 systems, as defined in this chapter, for inclusion as eligible basic
7 health care providers under the plan for subsidized enrollees,
8 nonsubsidized enrollees, or health coverage tax credit eligible
9 enrollees. The administrator shall endeavor to assure that covered
10 basic health care services are available to any enrollee of the plan
11 from among a selection of two or more participating managed health care
12 systems. In adopting any rules or procedures applicable to managed
13 health care systems and in its dealings with such systems, the
14 administrator shall consider and make suitable allowance for the need
15 for health care services and the differences in local availability of
16 health care resources, along with other resources, within and among the
17 several areas of the state. Contracts with participating managed
18 health care systems shall ensure that basic health plan enrollees who
19 become eligible for medical assistance may, at their option, continue
20 to receive services from their existing providers within the managed
21 health care system if such providers have entered into provider
22 agreements with the department of social and health services.

23 (10) To receive periodic premiums from or on behalf of subsidized,
24 nonsubsidized, and health coverage tax credit eligible enrollees,
25 deposit them in the basic health plan operating account, keep records
26 of enrollee status, and authorize periodic payments to managed health
27 care systems on the basis of the number of enrollees participating in
28 the respective managed health care systems.

29 (11) To accept applications from individuals residing in areas
30 served by the plan, on behalf of themselves and their spouses and
31 dependent children, for enrollment in the Washington basic health plan
32 as subsidized, nonsubsidized, or health coverage tax credit eligible
33 enrollees, to establish appropriate minimum-enrollment periods for
34 enrollees as may be necessary, and to determine, upon application and
35 on a reasonable schedule defined by the authority, or at the request of
36 any enrollee, eligibility due to current gross family income for
37 sliding scale premiums. Funds received by a family as part of
38 participation in the adoption support program authorized under RCW

1 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward
2 a family's current gross family income for the purposes of this
3 chapter. When an enrollee fails to report income or income changes
4 accurately, the administrator shall have the authority either to bill
5 the enrollee for the amounts overpaid by the state or to impose civil
6 penalties of up to two hundred percent of the amount of subsidy
7 overpaid due to the enrollee incorrectly reporting income. The
8 administrator shall adopt rules to define the appropriate application
9 of these sanctions and the processes to implement the sanctions
10 provided in this subsection, within available resources. No subsidy
11 may be paid with respect to any enrollee whose current gross family
12 income exceeds twice the federal poverty level or, subject to RCW
13 70.47.110, who is a recipient of medical assistance or medical care
14 services under chapter 74.09 RCW. If a number of enrollees drop their
15 enrollment for no apparent good cause, the administrator may establish
16 appropriate rules or requirements that are applicable to such
17 individuals before they will be allowed to reenroll in the plan.

18 (12) To accept applications from business owners on behalf of
19 themselves and their employees, spouses, and dependent children, as
20 subsidized or nonsubsidized enrollees, who reside in an area served by
21 the plan. The administrator may require all or the substantial
22 majority of the eligible employees of such businesses to enroll in the
23 plan and establish those procedures necessary to facilitate the orderly
24 enrollment of groups in the plan and into a managed health care system.
25 The administrator may require that a business owner pay at least an
26 amount equal to what the employee pays after the state pays its portion
27 of the subsidized premium cost of the plan on behalf of each employee
28 enrolled in the plan. Enrollment is limited to those not eligible for
29 medicare who wish to enroll in the plan and choose to obtain the basic
30 health care coverage and services from a managed care system
31 participating in the plan. The administrator shall adjust the amount
32 determined to be due on behalf of or from all such enrollees whenever
33 the amount negotiated by the administrator with the participating
34 managed health care system or systems is modified or the administrative
35 cost of providing the plan to such enrollees changes.

36 (13) To determine the rate to be paid to each participating managed
37 health care system in return for the provision of covered basic health
38 care services to enrollees in the system. Although the schedule of

1 covered basic health care services will be the same or actuarially
2 equivalent for similar enrollees, the rates negotiated with
3 participating managed health care systems may vary among the systems.
4 In negotiating rates with participating systems, the administrator
5 shall consider the characteristics of the populations served by the
6 respective systems, economic circumstances of the local area, the need
7 to conserve the resources of the basic health plan trust account, and
8 other factors the administrator finds relevant.

9 (14) To monitor the provision of covered services to enrollees by
10 participating managed health care systems in order to assure enrollee
11 access to good quality basic health care, to require periodic data
12 reports concerning the utilization of health care services rendered to
13 enrollees in order to provide adequate information for evaluation, and
14 to inspect the books and records of participating managed health care
15 systems to assure compliance with the purposes of this chapter. In
16 requiring reports from participating managed health care systems,
17 including data on services rendered enrollees, the administrator shall
18 endeavor to minimize costs, both to the managed health care systems and
19 to the plan. The administrator shall coordinate any such reporting
20 requirements with other state agencies, such as the insurance
21 commissioner and the department of health, to minimize duplication of
22 effort.

23 (15) To evaluate the effects this chapter has on private employer-
24 based health care coverage and to take appropriate measures consistent
25 with state and federal statutes that will discourage the reduction of
26 such coverage in the state.

27 (16) To develop a program of proven preventive health measures and
28 to integrate it into the plan wherever possible and consistent with
29 this chapter.

30 (17) To provide, consistent with available funding, assistance for
31 rural residents, underserved populations, and persons of color.

32 (18) In consultation with appropriate state and local government
33 agencies, to establish criteria defining eligibility for persons
34 confined or residing in government-operated institutions.

35 ~~((19) To administer the premium discounts provided under RCW~~
36 ~~48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington~~

1 ~~state health insurance pool.))~~

2 NEW SECTION. **Sec. 23.** This act takes effect January 1, 2006.

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