E2SHB 2319 - S AMD **174**
By Senators Becker, Kastama

NOT ADOPTED 03/01/2012

Strike everything after the enacting clause and insert the following:

"**PART I**
DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

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

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

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

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

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

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

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

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

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

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

PART II
THE WASHINGTON HEALTH BENEFIT EXCHANGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The exchange board shall study financing mechanisms to ensure that the exchange is self-sustaining by January 1, 2015. The board shall recommend a methodology of financing that takes into account alternative sources of funding and health plan affordability to the legislature by December 15, 2012.

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

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

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

PART III
QUALIFIED HEALTH PLANS

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

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

(a) Meets the requirements of Title 48 RCW and rules adopted thereunder by the commissioner pursuant to chapter 34.05 RCW so long as such rules do not exceed (b) of this subsection; and

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

(2) Consistent with section 1311 of P.L. 111-148 of 2010, as amended, the board shall allow stand-alone dental plans to offer coverage in the exchange beginning January 1, 2014. Dental benefits offered in the exchange must be offered and priced separately to assure transparency for consumers.

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

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

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

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

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

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

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

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

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

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

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

PART IV
ESSENTIAL HEALTH BENEFITS

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

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

(2) If the commissioner determines that the essential health benefits benchmark plan does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended, the commissioner shall only supplement the benchmark plan by reference to another benchmark plan option that includes services in the missing category pursuant to federal rules. In making this determination the commissioner must:

(a) Consult with an independent actuary; and

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

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

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

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

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

(5) Nothing in chapter. . ., Laws of 2012 (this act) prohibits the offering of benefits for spiritual care services deductible under section 213(d) of the internal revenue code (26 U.S.C. Sec. 213(d)) in plans inside or outside of the exchange.

PART V
THE WASHINGTON STATE HEALTH INSURANCE POOL

Sec. 10. RCW 48.41.170 and 1987 c 431 s 17 are each amended to read as follows:

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

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

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

(2) The commissioner shall adopt rules establishing the reinsurance program, as approved by the pool in section 11 of this act and reviewed

by the exchange board, consistent with P.L. 111-148 of 2010, as amended. The rules must establish the invisible high risk pool with the following:

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

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

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

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

(2) To further timely state implementation of the federal patient protection and affordable care act in the state, the pool board is authorized to conduct preoperational and planning activities related to these programs, including defining and implementing an appropriate legal structure or structures to administer and coordinate these programs. The legislature also directs the pool to develop and design a plan to administer the state-based reinsurance program as a permanent invisible high risk pool consistent with federal law. The plan must be approved by the pool board and the exchange board by December 1, 2012, prior to establishment and implementation and must include a recommendation for the governance structure of the pool if needed to administer any of the risk management functions per subsection (1) of this section. The pool shall, no later than January 1, 2013, make recommendations to the legislature for any statutory changes necessary to implement the plan developed according to this subsection.

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

(4) The pool shall report on these activities to the appropriate committees of the senate and house of representatives by December 15, 2012, and December 15, 2013. The reports shall also include

recommendations on additional mechanisms to address high-risk individuals both inside and outside of the exchange.

PART VI
MISCELLANEOUS

NEW SECTION. **Sec. 12.** The health care authority shall pursue an application for the state to participate in the individual market wellness program demonstration as described in section 2705 of P.L. 111-184 of 2010, as amended. The health care authority shall pursue activities that will prepare the state to apply for the demonstration project once announced by the United States department of health and human services.

NEW SECTION. **Sec. 13.** Sections 2, 3, 4, and 11 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and take effect immediately.

NEW SECTION. **Sec. 14.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected."

E2SHB 2319 - S AMD
By Senators Becker, Kastama

NOT ADOPTED 03/01/2012

On page 1, line 2 of the title, after "act;" strike the remainder of the title and insert "amending RCW 43.71.020, 43.71.030, 48.42.010, 48.42.020, and 48.41.170; reenacting and amending RCW 48.43.005; adding new sections to chapter 43.71 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 48.41 RCW; creating a new section; and declaring an emergency."

EFFECT: Prohibits members of the exchange board from lobbying. Requires the exchange to be operated in a manner consistent with, and not exceeding, the federal Affordable Care Act (ACA). Restores language that requires actions by the exchange and the board to be consistent with statutory direction. Defines "comparable health plan." Prohibits navigators from selling, soliciting, or negotiating insurance unless the navigator is licensed. Requires the exchange to allow insurance producers to enroll persons and entities in qualified health plans. Requires insurance producers enrolling individuals and entities inside the exchange to be compensated in the same manner as they would be outside the exchange. Deletes authority of the Commissioner to supplement the essential health benefits plan by rule. Requires the Commissioner to make recommendations to the legislature for supplemental benefits. Requires the Commissioner to consult with an independent actuary and HHS prior to making the determination or recommendation. Requires the Commissioner to take into account affordability and evidence-based medicine when making the recommendation. Eliminates the Insurance Commissioner's authority to adopt a rule prohibiting a Bronze plan from being offered outside the exchange unless it is offered inside the exchange. Eliminates the requirement that plans sold outside the exchange comply with the "metal" levels specified in the ACA. Eliminates the requirement that qualified health plans include tribal clinics and urban Indian clinics in their provider networks. Removes the authority for stand-alone dental plans to be sold in the exchange. Eliminates the rating system from qualified health plans. Requires appeals of board decisions regarding qualified health plans to be subject to the Administrative Procedure Act. Requires the largest small-group plan in the state to be designated as the "benchmark" plan for purposes of determining the essential health benefits. Requires any additional benefits added to the essential health benefits by the Insurance Commissioner to be no more than the extent necessary to comply with federal law. Allows a health plan to be sold in Washington unless the Insurance Commissioner finds that it is not substantially equal to the benchmark or does not cover the 10 essential health benefits categories in the ACA. Requires appeals of the Insurance Commissioner's findings to be subject to the Administrative Procedure Act - in any such proceeding the Insurance Commissioner has the burden to prove, by clear and convincing evidence, that the plan is not substantially equal to the benchmark or does not cover the 10 essential health benefits categories. Removes the authority for the state to establish the federal Basic Health Program. Removes the requirement for the Insurance Commissioner to establish the reinsurance program. Removes the requirement that enrollees in the Washington State Health Insurance Pool (WSHIP) be provided with exchange-like premium subsidies. Requires the pool to inform the legislature of statutory changes necessary to implement the invisible reinsurance mechanism it designs. Removes the requirement that the WSHIP be authorized by statute to administer the ACA's risk management functions; instead, allows the WSHIP to administer the risk management functions pursuant to a state contract providing funding. Requires the exchange board to report to the legislature on possible funding

methodology for the exchange to be self-sustaining by 2015. Clarifies that plans offered through the exchange must meet all applicable Title 48 RCW and chapter 284 WAC requirements as well as any rules issued by the Insurance Commissioner to implement the exchange. Clarifies that the Insurance Commissioner can only supplement the essential health benefit benchmark in accordance with HHS guidance. Removes sections related to WSHIP. Instructs the HCA to prepare the state to participate in the forthcoming HHS individual market wellness demonstration project.

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