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ENGROSSED SECOND SUBSTITUTE SENATE BILL 6067

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State of Washington

56th Legislature

2000 Regular Session

By Senate Committee on Health & Long-Term Care (originally sponsored by Senator Thibaudeau)

Read first time 02/04/00.

1 AN ACT Relating to access to individual health insurance coverage;  
2 amending RCW 48.04.010, 48.18.110, 48.20.028, 48.41.020, 48.41.030,  
3 48.41.040, 48.41.060, 48.41.080, 48.41.090, 48.41.100, 48.41.110,  
4 48.41.120, 48.41.130, 48.41.140, 48.41.200, 48.43.015, 48.43.025,  
5 48.43.035, 48.44.020, 48.44.022, 48.46.060, 48.46.064, 70.47.100,  
6 70.47.010, 70.47.020, and 41.05.140; reenacting and amending RCW  
7 48.43.005, 70.47.060, 43.84.092, 43.84.092, 43.84.092, and 43.79A.040;  
8 adding a new section to chapter 48.20 RCW; adding a new section to  
9 chapter 48.41 RCW; adding new sections to chapter 48.43 RCW; adding new  
10 sections to chapter 48.46 RCW; adding a new section to chapter 48.44  
11 RCW; adding a new section to chapter 48.01 RCW; adding a new section to  
12 chapter 41.05 RCW; creating new sections; repealing RCW 48.41.180;  
13 providing effective dates; providing an expiration date; and declaring  
14 an emergency.

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

16 **Sec. 1.** RCW 48.04.010 and 1990 1st ex.s. c 3 s 1 are each amended  
17 to read as follows:

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

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

5 (b) Upon written demand for a hearing made by any person aggrieved  
6 by any act, threatened act, or failure of the commissioner to act, if  
7 such failure is deemed an act under any provision of this code, or by  
8 any report, promulgation, or order of the commissioner other than an  
9 order on a hearing of which such person was given actual notice or at  
10 which such person appeared as a party, or order pursuant to the order  
11 on such hearing.

12 (2) Any such demand for a hearing shall specify in what respects  
13 such person is so aggrieved and the grounds to be relied upon as basis  
14 for the relief to be demanded at the hearing.

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

22 (4) If a hearing is demanded by a licensee whose license has been  
23 temporarily suspended pursuant to RCW 48.17.540, the commissioner shall  
24 hold such hearing demanded within thirty days after receipt of the  
25 demand or within thirty days of the effective date of a temporary  
26 license suspension issued after such demand, unless postponed by mutual  
27 consent.

28 (5) A licensee under this title may request that a hearing  
29 authorized under this section be presided over by an administrative law  
30 judge assigned under chapter 34.12 RCW. Any such request shall not be  
31 denied.

32 (6) Any hearing held relating to section 3, 29, or 32 of this act  
33 shall be presided over by an administrative law judge assigned under  
34 chapter 34.12 RCW.

35 **Sec. 2.** RCW 48.18.110 and 1985 c 264 s 9 are each amended to read  
36 as follows:

1 (1) The commissioner shall disapprove any such form of policy,  
2 application, rider, or endorsement, or withdraw any previous approval  
3 thereof, only:

4 (a) If it is in any respect in violation of or does not comply with  
5 this code or any applicable order or regulation of the commissioner  
6 issued pursuant to the code; or

7 (b) If it does not comply with any controlling filing theretofore  
8 made and approved; or

9 (c) If it contains or incorporates by reference any inconsistent,  
10 ambiguous or misleading clauses, or exceptions and conditions which  
11 unreasonably or deceptively affect the risk purported to be assumed in  
12 the general coverage of the contract; or

13 (d) If it has any title, heading, or other indication of its  
14 provisions which is misleading; or

15 (e) If purchase of insurance thereunder is being solicited by  
16 deceptive advertising.

17 (2) In addition to the grounds for disapproval of any such form as  
18 provided in subsection (1) of this section, the commissioner may  
19 disapprove any form of disability insurance policy, except an  
20 individual health benefit plan, if the benefits provided therein are  
21 unreasonable in relation to the premium charged.

22 NEW SECTION. Sec. 3. A new section is added to chapter 48.20 RCW  
23 to read as follows:

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

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

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.

37 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
38 plus any rate credits or recoupments less any refunds, for the

1 applicable period, whether received before, during, or after the  
2 applicable period.

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

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

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

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

13 (3) An insurer shall file with the notice required under subsection  
14 (2) of this section supporting documentation of its method of  
15 determining the rates charged. The commissioner may request only the  
16 following supporting documentation:

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

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

21 (c) The percentage of premium attributable in aggregate for  
22 nonclaims expenses used to determine the adjusted community rates  
23 charged; and

24 (d) A certification by a member of the American academy of  
25 actuaries, or other person approved by the commissioner, that the  
26 adjusted community rate charged can be reasonably expected to result in  
27 a loss ratio that meets or exceeds the loss ratio standard established  
28 in subsection (7) of this section.

29 (4) The commissioner may not disapprove or otherwise impede the  
30 implementation of the filed rates.

31 (5) By the last day of May each year any insurer providing  
32 individual health benefit plans in this state shall file for review by  
33 the commissioner supporting documentation of its actual loss ratio for  
34 its individual health benefit plans offered in the state in aggregate  
35 for the preceding calendar year. The filing shall include a  
36 certification by a member of the American academy of actuaries, or  
37 other person approved by the commissioner, that the actual loss ratio  
38 has been calculated in accordance with accepted actuarial principles.

1 (a) At the expiration of a thirty-day period beginning with the  
2 date the filing is delivered to the commissioner, the filing shall be  
3 deemed approved unless prior thereto the commissioner contests the  
4 calculation of the actual loss ratio.

5 (b) If the commissioner contests the calculation of the actual loss  
6 ratio, the commissioner shall state in writing the grounds for  
7 contesting the calculation to the insurer.

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

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

14 (a) The insurer shall calculate a percentage of premium to be  
15 remitted to the Washington state health insurance pool by subtracting  
16 the actual loss ratio for the preceding year from the loss ratio  
17 established in subsection (7) of this section.

18 (b) The remittance to the Washington state health insurance pool is  
19 the percentage calculated in (a) of the subsection, multiplied by the  
20 premium earned from each enrollee in the previous calendar year.  
21 Interest shall be added to the remittance due at a five percent annual  
22 rate calculated from the end of the calendar year for which the  
23 remittance is due to the date the remittance is made.

24 (c) All remittances shall be aggregated and such amounts shall be  
25 remitted to the Washington state high risk pool to be used as directed  
26 by the pool board of directors.

27 (d) Any remittance required to be issued under this section shall  
28 be issued within thirty days after the actual loss ratio is deemed  
29 approved under subsection (5)(a) of this section or the determination  
30 by an administrative law judge under subsection (5)(c) of this section.

31 (7) The loss ratio applicable to this section shall be seventy-four  
32 percent minus the premium tax rate applicable to the insurer's  
33 individual health benefit plans under RCW 48.14.0201.

34 **Sec. 4.** RCW 48.20.028 and 1997 c 231 s 207 are each amended to  
35 read as follows:

36 ~~(1)((a) An insurer offering any health benefit plan to any~~  
37 ~~individual shall offer and actively market to all individuals a health~~  
38 ~~benefit plan providing benefits identical to the schedule of covered~~

1 health benefits that are required to be delivered to an individual  
2 enrolled in the basic health plan subject to RCW 48.43.025 and  
3 48.43.035. Nothing in this subsection shall preclude an insurer from  
4 offering, or an individual from purchasing, other health benefit plans  
5 that may have more or less comprehensive benefits than the basic health  
6 plan, provided such plans are in accordance with this chapter. An  
7 insurer offering a health benefit plan that does not include benefits  
8 provided in the basic health plan shall clearly disclose these  
9 differences to the individual in a brochure approved by the  
10 commissioner.

11 (b) A health benefit plan shall provide coverage for hospital  
12 expenses and services rendered by a physician licensed under chapter  
13 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
14 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411,  
15 48.20.412, 48.20.416, and 48.20.420 if the health benefit plan is the  
16 mandatory offering under (a) of this subsection that provides benefits  
17 identical to the basic health plan, to the extent these requirements  
18 differ from the basic health plan.

19 (2)) Premiums for health benefit plans for individuals shall be  
20 calculated using the adjusted community rating method that spreads  
21 financial risk across the carrier's entire individual product  
22 population. All such rates shall conform to the following:

23 (a) The insurer shall develop its rates based on an adjusted  
24 community rate and may only vary the adjusted community rate for:

- 25 (i) Geographic area;
- 26 (ii) Family size;
- 27 (iii) Age;
- 28 (iv) Tenure discounts; and
- 29 (v) Wellness activities.

30 (b) The adjustment for age in (a)(iii) of this subsection may not  
31 use age brackets smaller than five-year increments which shall begin  
32 with age twenty and end with age sixty-five. Individuals under the age  
33 of twenty shall be treated as those age twenty.

34 (c) The insurer shall be permitted to develop separate rates for  
35 individuals age sixty-five or older for coverage for which medicare is  
36 the primary payer and coverage for which medicare is not the primary  
37 payer. Both rates shall be subject to the requirements of this  
38 subsection.

1 (d) The permitted rates for any age group shall be no more than  
2 four hundred twenty-five percent of the lowest rate for all age groups  
3 on January 1, 1996, four hundred percent on January 1, 1997, and three  
4 hundred seventy-five percent on January 1, 2000, and thereafter.

5 (e) A discount for wellness activities shall be permitted to  
6 reflect actuarially justified differences in utilization or cost  
7 attributed to such programs not to exceed twenty percent.

8 (f) The rate charged for a health benefit plan offered under this  
9 section may not be adjusted more frequently than annually except that  
10 the premium may be changed to reflect:

11 (i) Changes to the family composition;

12 (ii) Changes to the health benefit plan requested by the  
13 individual; or

14 (iii) Changes in government requirements affecting the health  
15 benefit plan.

16 (g) For the purposes of this section, a health benefit plan that  
17 contains a restricted network provision shall not be considered similar  
18 coverage to a health benefit plan that does not contain such a  
19 provision, provided that the restrictions of benefits to network  
20 providers result in substantial differences in claims costs. This  
21 subsection does not restrict or enhance the portability of benefits as  
22 provided in RCW 48.43.015.

23 (h) A tenure discount for continuous enrollment in the health plan  
24 of two years or more may be offered, not to exceed ten percent.

25 ~~((+3))~~ (2) Adjusted community rates established under this section  
26 shall pool the medical experience of all individuals purchasing  
27 coverage, and shall not be required to be pooled with the medical  
28 experience of health benefit plans offered to small employers under RCW  
29 48.21.045.

30 ~~((+4))~~ (3) As used in this section, "health benefit plan,"  
31 ~~(("basic health plan,"))~~ "adjusted community rate," and "wellness  
32 activities" mean the same as defined in RCW 48.43.005.

33 **Sec. 5.** RCW 48.41.020 and 1987 c 431 s 2 are each amended to read  
34 as follows:

35 It is the purpose and intent of the legislature to provide access  
36 to health insurance coverage to all residents of Washington who are  
37 denied ~~((adequate))~~ health insurance ~~((for any reason. It is the  
38 intent of the legislature that adequate levels of health insurance~~

1 coverage be made available to residents of Washington who are otherwise  
2 considered uninsurable or who are underinsured)). It is the intent of  
3 the Washington state health insurance coverage access act to provide a  
4 mechanism to ((insure)) ensure the availability of comprehensive health  
5 insurance to persons unable to obtain such insurance coverage on either  
6 an individual or group basis directly under any health plan.

7 **Sec. 6.** RCW 48.41.030 and 1997 c 337 s 6 are each amended to read  
8 as follows:

9 ((As used in this chapter, the following terms have the meaning  
10 indicated,)) The definitions in this section apply throughout this  
11 chapter unless the context clearly requires otherwise((÷)).

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

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

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

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

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

25 (6) "Health care facility" has the same meaning as in RCW  
26 70.38.025.

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

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

32 (9) "Health carrier" or "carrier" has the same meaning as in RCW  
33 48.43.005.

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

1 care, long-term care, dental, vision, accident, fixed indemnity,  
2 disability income contracts, civilian health and medical program for  
3 the uniform services (CHAMPUS), 10 U.S.C. 55, limited benefit or credit  
4 insurance, coverage issued as a supplement to liability insurance,  
5 insurance arising out of the worker's compensation or similar law,  
6 automobile medical payment insurance, or insurance under which benefits  
7 are payable with or without regard to fault and which is statutorily  
8 required to be contained in any liability insurance policy or  
9 equivalent self-insurance.

10 ~~((10))~~ (11) "Health plan" means any arrangement by which persons,  
11 including dependents or spouses, covered or making application to be  
12 covered under this pool, have access to hospital and medical benefits  
13 or reimbursement including any group or individual disability insurance  
14 policy; health care service contract; health maintenance agreement;  
15 uninsured arrangements of group or group-type contracts including  
16 employer self-insured, cost-plus, or other benefit methodologies not  
17 involving insurance or not governed by Title 48 RCW; coverage under  
18 group-type contracts which are not available to the general public and  
19 can be obtained only because of connection with a particular  
20 organization or group; and coverage by medicare or other governmental  
21 benefits. This term includes coverage through "health coverage" as  
22 defined under this section, and specifically excludes those types of  
23 programs excluded under the definition of "health coverage" in  
24 subsection ~~((9))~~ (10) of this section.

25 ~~((11))~~ (12) "Medical assistance" means coverage under Title XIX  
26 of the federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and  
27 chapter 74.09 RCW.

28 ~~((12))~~ (13) "Medicare" means coverage under Title XVIII of the  
29 Social Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

30 ~~((13))~~ (14) "Member" means any commercial insurer which provides  
31 disability insurance or stop loss insurance, any health care service  
32 contractor, and any health maintenance organization licensed under  
33 Title 48 RCW. "Member" also means the Washington state health care  
34 authority as issuer of the state uniform medical plan. "Member" shall  
35 also mean, as soon as authorized by federal law, employers and other  
36 entities, including a self-funding entity and employee welfare benefit  
37 plans that provide health plan benefits in this state on or after May  
38 18, 1987. "Member" does not include any insurer, health care service  
39 contractor, or health maintenance organization whose products are

1 exclusively dental products or those products excluded from the  
2 definition of "health coverage" set forth in subsection ~~((+9))~~ (10) of  
3 this section.

4 ~~((+14))~~ (15) "Network provider" means a health care provider who  
5 has contracted in writing with the pool administrator or a health  
6 carrier contracting with the pool administrator to offer pool coverage  
7 to accept payment from and to look solely to the pool or health carrier  
8 according to the terms of the pool health plans.

9 ~~((+15))~~ (16) "Plan of operation" means the pool, including  
10 articles, by-laws, and operating rules, adopted by the board pursuant  
11 to RCW 48.41.050.

12 ~~((+16))~~ (17) "Point of service plan" means a benefit plan offered  
13 by the pool under which a covered person may elect to receive covered  
14 services from network providers, or nonnetwork providers at a reduced  
15 rate of benefits.

16 ~~((+17))~~ (18) "Pool" means the Washington state health insurance  
17 pool as created in RCW 48.41.040.

18 ~~((+18) "Substantially equivalent health plan" means a "health plan"~~  
19 ~~as defined in subsection (10) of this section which, in the judgment of~~  
20 ~~the board or the administrator, offers persons including dependents or~~  
21 ~~spouses covered or making application to be covered by this pool an~~  
22 ~~overall level of benefits deemed approximately equivalent to the~~  
23 ~~minimum benefits available under this pool.))~~

24 **Sec. 7.** RCW 48.41.040 and 1989 c 121 s 2 are each amended to read  
25 as follows:

26 (1) There is ~~((hereby))~~ created a nonprofit entity to be known as  
27 the Washington state health insurance pool. All members in this state  
28 on or after May 18, 1987, shall be members of the pool. When  
29 authorized by federal law, all self-insured employers shall also be  
30 members of the pool.

31 (2) Pursuant to chapter 34.05 RCW the commissioner shall, within  
32 ninety days after May 18, 1987, give notice to all members of the time  
33 and place for the initial organizational meetings of the pool. A board  
34 of directors shall be established, which shall be comprised of ~~((nine))~~  
35 ten members. ~~((The commissioner shall select three members of the~~  
36 ~~board who shall represent (a) the general public, (b) health care~~  
37 ~~providers, and (c) health insurance agents.))~~ The governor shall  
38 select one member of the board from each list of three nominees

1 submitted by state-wide organizations representing each of the  
2 following: (a) Health care providers; (b) health insurance agents; (c)  
3 small employers; and (d) large employers. The governor shall select  
4 two members of the board from a list of nominees submitted by state-  
5 wide organizations representing health care consumers. The remaining  
6 four members of the board shall be selected by election from among the  
7 members of the pool. The elected members shall, to the extent  
8 possible, include at least one representative of health care service  
9 contractors, one representative of health maintenance organizations,  
10 and one representative of commercial insurers which provides disability  
11 insurance. The members of the board shall elect a chair from the  
12 voting members of the board. The insurance commissioner shall be a  
13 nonvoting, ex officio member. When self-insured organizations other  
14 than the Washington state health care authority become eligible for  
15 participation in the pool, the membership of the board shall be  
16 increased to eleven and at least one member of the board shall  
17 represent the self-insurers.

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

23 (4) The board shall submit to the commissioner a plan of operation  
24 for the pool and any amendments thereto necessary or suitable to assure  
25 the fair, reasonable, and equitable administration of the pool. The  
26 commissioner shall, after notice and hearing pursuant to chapter 34.05  
27 RCW, approve the plan of operation if it is determined to assure the  
28 fair, reasonable, and equitable administration of the pool and provides  
29 for the sharing of pool losses on an equitable, proportionate basis  
30 among the members of the pool. The plan of operation shall become  
31 effective upon approval in writing by the commissioner consistent with  
32 the date on which the coverage under this chapter must be made  
33 available. If the board fails to submit a plan of operation within one  
34 hundred eighty days after the appointment of the board or any time  
35 thereafter fails to submit acceptable amendments to the plan, the  
36 commissioner shall, within ninety days after notice and hearing  
37 pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are  
38 necessary or advisable to effectuate this chapter. The rules shall

1 continue in force until modified by the commissioner or superseded by  
2 a plan submitted by the board and approved by the commissioner.

3 NEW SECTION. **Sec. 8.** Sixty days from the effective date of this  
4 section, the existing board of directors of the Washington state health  
5 insurance pool shall be dissolved, and the appointment or election of  
6 new members under RCW 48.41.040 shall be effective. For purposes of  
7 setting terms, the new members shall be treated as original members.

8 **Sec. 9.** RCW 48.41.060 and 1997 c 337 s 5 are each amended to read  
9 as follows:

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

15 ~~(1) Enter into contracts as are necessary or proper to carry out~~  
16 ~~the provisions and purposes of this chapter including the authority,~~  
17 ~~with the approval of the commissioner, to enter into contracts with~~  
18 ~~similar pools of other states for the joint performance of common~~  
19 ~~administrative functions, or with persons or other organizations for~~  
20 ~~the performance of administrative functions;~~

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

24 ~~(3)) shall:~~

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

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

4 (c) Approve the standard health questionnaire and any modifications  
5 needed to comply with this chapter. The standard health questionnaire  
6 shall be submitted to an actuary for certification, modified as  
7 necessary, and approved at least every eighteen months. The  
8 designation and approval of the standard health questionnaire by the  
9 board shall not be subject to review and approval by the commissioner.  
10 The standard health questionnaire or any modification thereto shall not  
11 be used until ninety days after public notice of the approval of the  
12 questionnaire or any modification thereto, except that the initial  
13 standard health questionnaire approved for use by the board after the  
14 effective date of this section may be used immediately following public  
15 notice of such approval;

16 (d) Establish appropriate rates, rate schedules, rate adjustments,  
17 expense allowances, ((agent referral fees,)) claim reserve formulas and  
18 any other actuarial functions appropriate to the operation of the pool.  
19 Rates shall not be unreasonable in relation to the coverage provided,  
20 the risk experience, and expenses of providing the coverage. Rates and  
21 rate schedules may be adjusted for appropriate risk factors such as age  
22 and area variation in claim costs and shall take into consideration  
23 appropriate risk factors in accordance with established actuarial  
24 underwriting practices consistent with Washington state ((small group))  
25 individual plan rating requirements under RCW ((48.44.023—and  
26 48.46.066)) 48.44.022 and 48.46.064;

27 ((+4)) (e) Assess members of the pool in accordance with the  
28 provisions of this chapter, and make advance interim assessments as may  
29 be reasonable and necessary for the organizational or interim operating  
30 expenses. Any interim assessments will be credited as offsets against  
31 any regular assessments due following the close of the year;

32 ((+5)) (f) Issue policies of health coverage in accordance with  
33 the requirements of this chapter;

34 ((+6)) (g) Establish procedures for the administration of the  
35 premium discount provided under RCW 48.41.200(3)(a)(iii);

36 (h) Contract with the Washington state health care authority for  
37 the administration of the premium discounts provided under RCW  
38 48.41.200(3)(a) (i) and (ii);

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

4 (j) Provide certification to the commissioner when assessments will  
5 exceed the threshold level established in section 36 of this act.

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

7 (a) Enter into contracts as are necessary or proper to carry out  
8 the provisions and purposes of this chapter including the authority,  
9 with the approval of the commissioner, to enter into contracts with  
10 similar pools of other states for the joint performance of common  
11 administrative functions, or with persons or other organizations for  
12 the performance of administrative functions;

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

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

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

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

26 **Sec. 10.** RCW 48.41.080 and 1997 c 231 s 212 are each amended to  
27 read as follows:

28 The board shall select an administrator ~~((from the membership of~~  
29 ~~the pool whether domiciled in this state or another state))~~ through a  
30 competitive bidding process to administer the pool.

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

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

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

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

36 and

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

1 (2) The administrator shall serve for a period of three years  
2 subject to removal for cause. At least six months prior to the  
3 expiration of each three-year period of service by the administrator,  
4 the board shall invite all interested parties, including the current  
5 administrator, to submit bids to serve as the administrator for the  
6 succeeding three-year period. Selection of the administrator for this  
7 succeeding period shall be made at least three months prior to the end  
8 of the current three-year period.

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

11 (a) (~~All~~) Administering eligibility and administrative claim  
12 payment functions relating to the pool;

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

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

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

22 (ii) Taking steps necessary to offer and administer managed care  
23 benefit plans; and

24 (iii) Evaluating the eligibility of each claim for payment by the  
25 pool;

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

29 (e) Following the close of each accounting year, determination of  
30 net paid and earned premiums, the expense of administration, and the  
31 paid and incurred losses for the year and reporting this information to  
32 the board and the commissioner on a form as prescribed by the  
33 commissioner.

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

37 **Sec. 11.** RCW 48.41.090 and 1989 c 121 s 6 are each amended to read  
38 as follows:

1 (1) Following the close of each accounting year, the pool  
2 administrator shall determine the net premium (premiums less  
3 administrative expense allowances), the pool expenses of  
4 administration, and incurred losses for the year, taking into account  
5 investment income and other appropriate gains and losses.

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

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

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

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

25 (c) Except as provided in section 36 of this act, any deficit  
26 incurred by the pool shall be recouped by assessments among members  
27 apportioned under this subsection pursuant to the formula set forth by  
28 the board among members.

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

38 (4) If assessments exceed actual losses and administrative expenses  
39 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 **Sec. 12.** RCW 48.41.100 and 1995 c 34 s 5 are each amended to read  
5 as follows:

6 (1) (~~Any individual~~) The following persons who ((is a)) are  
7 residents of this state ((is)) are eligible for pool coverage ((upon  
8 providing evidence of rejection for medical reasons, a requirement of  
9 restrictive riders, an up-rated premium, or a preexisting conditions  
10 limitation on health insurance, the effect of which is to substantially  
11 reduce coverage from that received by a person considered a standard  
12 risk, by at least one member within six months of the date of  
13 application. Evidence of rejection may be waived in accordance with  
14 rules adopted by the board))):

15 (a) Any person who provides evidence of a carrier's decision not to  
16 accept him or her for enrollment in an individual health benefit plan  
17 as defined in RCW 48.43.005 based upon, and within ninety days of the  
18 receipt of, the results of the standard health questionnaire designated  
19 by the board and administered by health carriers under section 21 of  
20 this act;

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

25 (c) Any person who resides in a county of the state where no  
26 carrier or insurer regulated under chapter 48.15 RCW offers to the  
27 public an individual health benefit plan other than a catastrophic  
28 health plan as defined in RCW 48.43.005 at the time of application to  
29 the pool, and who makes direct application to the pool; and

30 (d) Any medicare eligible person upon providing evidence of  
31 rejection for medical reasons, a requirement of restrictive riders, an  
32 up-rated premium, or a preexisting conditions limitation on a medicare  
33 supplemental insurance policy under chapter 48.66 RCW, the effect of  
34 which is to substantially reduce coverage from that received by a  
35 person considered a standard risk by at least one member within six  
36 months of the date of application.

37 (2) The following persons are not eligible for coverage by the  
38 pool:

1 (a) Any person having terminated coverage in the pool unless (i)  
2 twelve months have lapsed since termination, or (ii) that person can  
3 show continuous other coverage which has been involuntarily terminated  
4 for any reason other than nonpayment of premiums;

5 (b) Any person on whose behalf the pool has paid out (~~five hundred~~  
6 ~~thousand~~) one million dollars in benefits;

7 (c) Inmates of public institutions and persons whose benefits are  
8 duplicated under public programs;

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

16 (3) (~~Any person whose health insurance coverage is involuntarily~~  
17 ~~terminated for any reason other than nonpayment of premium may apply~~  
18 ~~for coverage under the plan.)) When a carrier or insurer regulated  
19 under chapter 48.15 RCW begins to offer an individual health benefit  
20 plan in a county where no carrier had been offering an individual  
21 health benefit plan:~~

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

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

36 (c) The pool administrator shall provide written notice to any  
37 person who is no longer eligible for coverage under a pool plan under  
38 this subsection (3) within thirty days of the administrator's  
39 determination that the person is no longer eligible. The notice shall:

1 (i) Indicate that coverage under the plan will cease ninety days from  
2 the date that the notice is dated; (ii) describe any other coverage  
3 options, either in or outside of the pool, available to the person;  
4 (iii) describe the procedures for the administration of the standard  
5 health questionnaire to determine the person's continued eligibility  
6 for coverage under subsection (1)(b) of this section; and (iv) describe  
7 the enrollment process for the available options outside of the pool.

8 **Sec. 13.** RCW 48.41.110 and 1997 c 231 s 213 are each amended to  
9 read as follows:

10 (1) The pool ~~((is authorized to))~~ shall offer one or more  
11 ~~((managed))~~ care management plans of coverage. Such plans may, but are  
12 not required to, include point of service features that permit  
13 participants to receive in-network benefits or out-of-network benefits  
14 subject to differential cost shares. Covered persons enrolled in the  
15 pool on January 1, ~~((1997))~~ 2001, may continue coverage under the pool  
16 plan in which they are enrolled on that date. However, the pool may  
17 incorporate managed care features into such existing plans.

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

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

31 (a) Hospital services, including charges for the most common  
32 semiprivate room, for the most common private room if semiprivate rooms  
33 do not exist in the health care facility, or for the private room if  
34 medically necessary, but limited to a total of one hundred eighty  
35 inpatient days in a calendar year, and limited to thirty days inpatient  
36 care for mental and nervous conditions, or alcohol, drug, or chemical  
37 dependency or abuse per calendar year;

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

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

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

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

19 (f) Services of a home health agency;

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

22 (h) Oxygen;

23 (i) Anesthesia services;

24 (j) Prostheses, other than dental;

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

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

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

35 (n) Maternity care services(~~(, as provided in the managed care plan~~  
36 ~~to be designed by the pool board of directors, and for which no~~  
37 ~~preexisting condition waiting periods may apply))~~);

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

1 (p) Hospice services;

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

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

7 ~~((+3))~~ (4) The board shall design and employ cost containment  
8 measures and requirements such as, but not limited to, care  
9 coordination, provider network limitations, preadmission certification,  
10 and concurrent inpatient review which may make the pool more cost-  
11 effective.

12 ~~((+4))~~ (5) The pool benefit policy may contain benefit  
13 limitations, exceptions, and cost shares such as copayments,  
14 coinsurance, and deductibles that are consistent with managed care  
15 products, except that differential cost shares may be adopted by the  
16 board for nonnetwork providers under point of service plans. The pool  
17 benefit policy cost shares and limitations must be consistent with  
18 those that are generally included in health plans approved by the  
19 insurance commissioner; however, no limitation, exception, or reduction  
20 may be used that would exclude coverage for any disease, illness, or  
21 injury.

22 ~~((+5))~~ (6) The pool may not reject an individual for health plan  
23 coverage based upon preexisting conditions of the individual or deny,  
24 exclude, or otherwise limit coverage for an individual's preexisting  
25 health conditions; except that it ~~((may))~~ shall impose a ~~((three-~~  
26 ~~month))~~ six-month benefit waiting period for preexisting conditions for  
27 which medical advice was given, ~~((or))~~ for which a health care provider  
28 recommended or provided treatment, or for which a prudent layperson  
29 would have sought advice or treatment, within ~~((three))~~ six months  
30 before the effective date of coverage. The preexisting condition  
31 waiting period shall not apply to prenatal care services. The pool may  
32 not avoid the requirements of this section through the creation of a  
33 new rate classification or the modification of an existing rate  
34 classification. Credit against the waiting period shall be as provided  
35 in subsection (7) of this section.

36 (7) The pool shall credit any preexisting condition waiting period  
37 in its plans for a person who was enrolled at any time during the  
38 sixty-three day period immediately preceding the date of application  
39 for the new pool plan in a group health benefit plan or an individual

1 health benefit plan other than a catastrophic health plan. The carrier  
2 must credit the period of coverage the person was continuously covered  
3 under the immediately preceding health plan toward the waiting period  
4 of the new health plan. For the purposes of this subsection, a  
5 preceding health plan includes an employer-provided self-funded health  
6 plan.

7 **Sec. 14.** RCW 48.41.120 and 1989 c 121 s 8 are each amended to read  
8 as follows:

9 (1) Subject to the limitation provided in subsection (3) of this  
10 section, a pool policy offered in accordance with (~~this chapter~~) RCW  
11 48.41.110(3) shall impose a deductible. Deductibles of five hundred  
12 dollars and one thousand dollars on a per person per calendar year  
13 basis shall initially be offered. The board may authorize deductibles  
14 in other amounts. The deductible shall be applied to the first five  
15 hundred dollars, one thousand dollars, or other authorized amount of  
16 eligible expenses incurred by the covered person.

17 (2) Subject to the limitations provided in subsection (3) of this  
18 section, a mandatory coinsurance requirement shall be imposed at the  
19 rate of twenty percent of eligible expenses in excess of the mandatory  
20 deductible.

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

25 (a) One thousand five hundred dollars per individual, or three  
26 thousand dollars per family, per calendar year for the five hundred  
27 dollar deductible policy;

28 (b) Two thousand five hundred dollars per individual, or five  
29 thousand dollars per family per calendar year for the one thousand  
30 dollar deductible policy; or

31 (c) An amount authorized by the board for any other deductible  
32 policy.

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

36 **Sec. 15.** RCW 48.41.130 and 1997 c 231 s 215 are each amended to  
37 read as follows:

1 All policy forms issued by the pool shall conform in substance to  
2 prototype forms developed by the pool, and shall in all other respects  
3 conform to the requirements of this chapter, and shall be filed with  
4 and approved by the commissioner before they are issued. (~~The pool  
5 shall not issue a pool policy to any individual who, on the effective  
6 date of the coverage applied for, already has or would have coverage  
7 substantially equivalent to a pool policy as an insured or covered  
8 dependent, or who would be eligible for such coverage if he or she  
9 elected to obtain it at a lesser premium rate. However, coverage  
10 provided by the basic health plan, as established pursuant to chapter  
11 70.47 RCW, shall not be deemed substantially equivalent for the  
12 purposes of this section.~~)

13 **Sec. 16.** RCW 48.41.140 and 1987 c 431 s 14 are each amended to  
14 read as follows:

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

32 (2) A pool policy shall provide that coverage of a dependent,  
33 unmarried person shall terminate when the person becomes nineteen years  
34 of age: PROVIDED, That coverage of such person shall not terminate at  
35 age nineteen while he or she is and continues to be both (a) incapable  
36 of self-sustaining employment by reason of developmental disability or  
37 physical handicap and (b) chiefly dependent upon the person in whose  
38 name the policy is issued for support and maintenance, provided proof

1 of such incapacity and dependency is furnished to the pool by the  
2 policyholder within thirty-one days of the dependent's attainment of  
3 age nineteen and subsequently as may be required by the pool but not  
4 more frequently than annually after the two-year period following the  
5 dependent's attainment of age nineteen.

6 ~~((3) A pool policy may contain provisions under which coverage is  
7 excluded during a period of six months following the effective date of  
8 coverage as to a given covered individual for preexisting conditions,  
9 as long as medical advice or treatment was recommended or received  
10 within a period of six months before the effective date of coverage.~~

11 ~~These preexisting condition exclusions shall be waived to the  
12 extent to which similar exclusions have been satisfied under any prior  
13 health insurance which was for any reason other than nonpayment of  
14 premium involuntarily terminated, if the application for pool coverage  
15 is made not later than thirty days following the involuntary  
16 termination. In that case, with payment of appropriate premium,  
17 coverage in the pool shall be effective from the date on which the  
18 prior coverage was terminated.))~~

19 **Sec. 17.** RCW 48.41.200 and 1997 c 231 s 214 are each amended to  
20 read as follows:

21 (1) The pool shall determine the standard risk rate by calculating  
22 the average ((group)) individual standard rate ((for groups comprised  
23 of up to fifty persons)) charged for coverage comparable to pool  
24 coverage by the five largest members, measured in terms of individual  
25 market enrollment, offering such coverages in the state ((comparable to  
26 the pool coverage)). In the event five members do not offer comparable  
27 coverage, the standard risk rate shall be established using reasonable  
28 actuarial techniques and shall reflect anticipated experience and  
29 expenses for such coverage in the individual market.

30 (2) Subject to subsection (3) of this section, maximum rates for  
31 pool coverage shall be ((one hundred fifty percent for the indemnity  
32 health plan and one hundred twenty five percent for managed care plans  
33 of the rates established as applicable for group standard risks in  
34 groups comprised of up to fifty persons)) as follows:

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

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

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

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

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

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

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

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

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

28 (b) In no event shall the rate for any person be less than one  
29 hundred ten percent of the rate calculated under subsection (1) of this  
30 section.

31 (c) Rate reductions under (a)(i) and (ii) of this subsection shall  
32 be available only to the extent that funds are specifically  
33 appropriated for this purpose in the omnibus appropriations act.

34 **Sec. 18.** RCW 48.43.005 and 1997 c 231 s 202 and 1997 c 55 s 1 are  
35 each reenacted and amended to read as follows:

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

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

5 (2) "Basic health plan" means the plan described under chapter  
6 70.47 RCW, as revised from time to time.

7 (~~(3) ("Basic health plan model plan" means a health plan as  
8 required in RCW 70.47.060(2)(d).~~

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

13 (~~(5))~~ (4) "Catastrophic health plan" means:

14 (a) In the case of a contract, agreement, or policy covering a  
15 single enrollee, a health benefit plan requiring a calendar year  
16 deductible of, at a minimum, one thousand five hundred dollars and an  
17 annual out-of-pocket expense required to be paid under the plan (other  
18 than for premiums) for covered benefits of at least three thousand  
19 dollars; and

20 (b) In the case of a contract, agreement, or policy covering more  
21 than one enrollee, a health benefit plan requiring a calendar year  
22 deductible of, at a minimum, three thousand dollars and an annual out-  
23 of-pocket expense required to be paid under the plan (other than for  
24 premiums) for covered benefits of at least five thousand five hundred  
25 dollars; or

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

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

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

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

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

8 (9) "Eligible employee" means an employee who works on a full-time  
9 basis with a normal work week of thirty or more hours. The term  
10 includes a self-employed individual, including a sole proprietor, a  
11 partner of a partnership, and may include an independent contractor, if  
12 the self-employed individual, sole proprietor, partner, or independent  
13 contractor is included as an employee under a health benefit plan of a  
14 small employer, but does not work less than thirty hours per week and  
15 derives at least seventy-five percent of his or her income from a trade  
16 or business through which he or she has attempted to earn taxable  
17 income and for which he or she has filed the appropriate internal  
18 revenue service form. Persons covered under a health benefit plan  
19 pursuant to the consolidated omnibus budget reconciliation act of 1986  
20 shall not be considered eligible employees for purposes of minimum  
21 participation requirements of chapter 265, Laws of 1995.

22 (10) "Emergency medical condition" means the emergent and acute  
23 onset of a symptom or symptoms, including severe pain, that would lead  
24 a prudent layperson acting reasonably to believe that a health  
25 condition exists that requires immediate medical attention, if failure  
26 to provide medical attention would result in serious impairment to  
27 bodily functions or serious dysfunction of a bodily organ or part, or  
28 would place the person's health in serious jeopardy.

29 (11) "Emergency services" means otherwise covered health care  
30 services medically necessary to evaluate and treat an emergency medical  
31 condition, provided in a hospital emergency department.

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

36 (13) "Grievance" means a written complaint submitted by or on  
37 behalf of a covered person regarding: (a) Denial of payment for  
38 medical services or nonprovision of medical services included in the  
39 covered person's health benefit plan, or (b) service delivery issues

1 other than denial of payment for medical services or nonprovision of  
2 medical services, including dissatisfaction with medical care, waiting  
3 time for medical services, provider or staff attitude or demeanor, or  
4 dissatisfaction with service provided by the health carrier.

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

18 (15) "Health care provider" or "provider" means:

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

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

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

27 (17) "Health carrier" or "carrier" means a disability insurer  
28 regulated under chapter 48.20 or 48.21 RCW, a health care service  
29 contractor as defined in RCW 48.44.010, or a health maintenance  
30 organization as defined in RCW 48.46.020.

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

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

35 (b) Medicare supplemental health insurance governed by chapter  
36 48.66 RCW;

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

39 (d) Disability income;

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

4 (f) Workers' compensation coverage;

5 (g) Accident only coverage;

6 (h) Specified disease and hospital confinement indemnity when  
7 marketed solely as a supplement to a health plan;

8 (i) Employer-sponsored self-funded health plans;

9 (j) Dental only and vision only coverage; and

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

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

20 (~~(20) ("Open enrollment" means the annual sixty-two day period~~  
21 ~~during the months of July and August during which every health carrier~~  
22 ~~offering individual health plan coverage must accept onto individual~~  
23 ~~coverage any state resident within the carrier's service area~~  
24 ~~regardless of health condition who submits an application in accordance~~  
25 ~~with RCW 48.43.035(1).~~

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

29 (~~(22)~~) (21) "Premium" means all sums charged, received, or  
30 deposited by a health carrier as consideration for a health plan or the  
31 continuance of a health plan. Any assessment or any "membership,"  
32 "policy," "contract," "service," or similar fee or charge made by a  
33 health carrier in consideration for a health plan is deemed part of the  
34 premium. "Premium" shall not include amounts paid as enrollee point-  
35 of-service cost-sharing.

36 (~~(23)~~) (22) "Review organization" means a disability insurer  
37 regulated under chapter 48.20 or 48.21 RCW, health care service  
38 contractor as defined in RCW 48.44.010, or health maintenance  
39 organization as defined in RCW 48.46.020, and entities affiliated with,

1 under contract with, or acting on behalf of a health carrier to perform  
2 a utilization review.

3 ~~((24))~~ (23) "Small employer" or "small group" means any person,  
4 firm, corporation, partnership, association, political subdivision  
5 except school districts, or self-employed individual that is actively  
6 engaged in business that, on at least fifty percent of its working days  
7 during the preceding calendar quarter, employed no more than fifty  
8 eligible employees, with a normal work week of thirty or more hours,  
9 the majority of whom were employed within this state, and is not formed  
10 primarily for purposes of buying health insurance and in which a bona  
11 fide employer-employee relationship exists. In determining the number  
12 of eligible employees, companies that are affiliated companies, or that  
13 are eligible to file a combined tax return for purposes of taxation by  
14 this state, shall be considered an employer. Subsequent to the  
15 issuance of a health plan to a small employer and for the purpose of  
16 determining eligibility, the size of a small employer shall be  
17 determined annually. Except as otherwise specifically provided, a  
18 small employer shall continue to be considered a small employer until  
19 the plan anniversary following the date the small employer no longer  
20 meets the requirements of this definition. The term "small employer"  
21 includes a self-employed individual or sole proprietor. The term  
22 "small employer" also includes a self-employed individual or sole  
23 proprietor who derives at least seventy-five percent of his or her  
24 income from a trade or business through which the individual or sole  
25 proprietor has attempted to earn taxable income and for which he or she  
26 has filed the appropriate internal revenue service form 1040, schedule  
27 C or F, for the previous taxable year.

28 ~~((25))~~ (24) "Utilization review" means the prospective,  
29 concurrent, or retrospective assessment of the necessity and  
30 appropriateness of the allocation of health care resources and services  
31 of a provider or facility, given or proposed to be given to an enrollee  
32 or group of enrollees.

33 ~~((26))~~ (25) "Wellness activity" means an explicit program of an  
34 activity consistent with department of health guidelines, such as,  
35 smoking cessation, injury and accident prevention, reduction of alcohol  
36 misuse, appropriate weight reduction, exercise, automobile and  
37 motorcycle safety, blood cholesterol reduction, and nutrition education  
38 for the purpose of improving enrollee health status and reducing health  
39 service costs.

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

3        (1) No carrier may reject an individual for an individual health  
4 benefit plan based upon preexisting conditions of the individual except  
5 as provided in section 21 of this act.

6        (2) No carrier may deny, exclude, or otherwise limit coverage for  
7 an individual's preexisting health conditions except as provided in  
8 this section.

9        (3) For an individual health benefit plan originally issued on or  
10 after the effective date of this section preexisting condition waiting  
11 periods imposed upon a person enrolling in an individual health benefit  
12 plan shall be no more than nine months for a preexisting condition for  
13 which medical advice was given, for which a health care provider  
14 recommended or provided treatment, or for which a prudent layperson  
15 would have sought advice or treatment, within six months prior to the  
16 effective date of the plan.

17        (4) Individual health benefit plan preexisting condition waiting  
18 periods shall not apply to prenatal care services.

19        (5) No carrier may avoid the requirements of this section through  
20 the creation of a new rate classification or the modification of an  
21 existing rate classification.    A new or changed rate classification  
22 will be deemed an attempt to avoid the provisions of this section if  
23 the new or changed classification would substantially discourage  
24 applications for coverage from individuals who are higher than average  
25 health risks.    These provisions apply only to individuals who are  
26 Washington residents.

27        **Sec. 20.**    RCW 48.43.015 and 1995 c 265 s 5 are each amended to read  
28 as follows:

29        (1) For a health benefit plan offered to a group other than a small  
30 group, every health carrier shall ((waive)) reduce any preexisting  
31 condition exclusion or limitation for persons or groups who had similar  
32 health coverage under a different health plan at any time during the  
33 three-month period immediately preceding the date of application for  
34 the new health plan if such person was continuously covered under the  
35 immediately preceding health plan.    If the person was continuously  
36 covered for at least three months under the immediately preceding  
37 health plan, the carrier may not impose a waiting period for coverage  
38 of preexisting conditions.    If the person was continuously covered for

1 less than three months under the immediately preceding health plan, the  
2 carrier must credit any waiting period under the immediately preceding  
3 health plan toward the new health plan. For the purposes of this  
4 subsection, a preceding health plan includes an employer provided self-  
5 funded health plan and plans of the Washington state health insurance  
6 pool.

7 (2) For a health benefit plan offered to a small group, every  
8 health carrier shall reduce any preexisting condition exclusion or  
9 limitation for persons or groups who had similar health coverage under  
10 a different health plan at any time during the three-month period  
11 immediately preceding the date of application for the new health plan  
12 if such person was continuously covered under the immediately preceding  
13 health plan. If the person was continuously covered for at least nine  
14 months under the immediately preceding health plan, the carrier may not  
15 impose a waiting period for coverage of preexisting conditions. If the  
16 person was continuously covered for less than nine months under the  
17 immediately preceding health plan, the carrier must credit any waiting  
18 period under the immediately preceding health plan toward the new  
19 health plan. For the purposes of this subsection, a preceding health  
20 plan includes an employer provided self-funded health plan and plans of  
21 the Washington state health insurance pool.

22 (3) For a health benefit plan offered to an individual, every  
23 health carrier shall credit any preexisting condition waiting period in  
24 that plan for a person who was enrolled at any time during the sixty-  
25 three day period immediately preceding the date of application for the  
26 new health plan in a group health benefit plan or an individual health  
27 benefit plan, other than a catastrophic health plan, and (a) the  
28 benefits under the previous plan provide equivalent or greater overall  
29 benefit coverage than that provided in the health benefit plan the  
30 individual seeks to purchase; or (b) the person is seeking an  
31 individual health benefit plan due to his or her change of residence  
32 from one geographic area in Washington state to another geographic area  
33 in Washington state where his or her current health plan is not  
34 offered; or (c) The person is seeking an individual health benefit  
35 plan: (i) Because a health care provider with whom he or she has an  
36 established care relationship and from whom he or she has received  
37 treatment within the past twelve months is no longer part of the  
38 carrier's provider network under his or her existing Washington  
39 individual health benefit plan; and (ii) his or her health care

1 provider is part of another carrier's provider network; and (iii)  
2 application for a health benefit plan under that carrier's provider  
3 network individual coverage is made within ninety days of his or her  
4 provider leaving the previous carrier's provider network. The carrier  
5 must credit the period of coverage the person was continuously covered  
6 under the immediately preceding health plan toward the waiting period  
7 of the new health plan. For the purposes of this subsection (3), a  
8 preceding health plan includes an employer-provided self-funded health  
9 plan and plans of the Washington state health insurance pool.

10 (4) Subject to the provisions of subsections (1) through (3) of  
11 this section, nothing contained in this section requires a health  
12 carrier to amend a health plan to provide new benefits in its existing  
13 health plans. In addition, nothing in this section requires a carrier  
14 to waive benefit limitations not related to an individual or group's  
15 preexisting conditions or health history.

16 NEW SECTION. Sec. 21. A new section is added to chapter 48.43 RCW  
17 to read as follows:

18 (1) Except as provided in (a) and (b) of this subsection, a health  
19 carrier may require any person applying for an individual health  
20 benefit plan to complete the standard health questionnaire designated  
21 under chapter 48.41 RCW.

22 (a) If a person is seeking an individual health benefit plan due to  
23 his or her change of residence from one geographic area in Washington  
24 state to another geographic area in Washington state where his or her  
25 current health plan is not offered, completion of the standard health  
26 questionnaire shall not be a condition of coverage if application for  
27 coverage is made within ninety days of relocation.

28 (b) If a person is seeking an individual health benefit plan:

29 (i) Because a health care provider with whom he or she has an  
30 established care relationship and from whom he or she has received  
31 treatment within the past twelve months is no longer part of the  
32 carrier's provider network under his or her existing Washington  
33 individual health benefit plan; and

34 (ii) His or her health care provider is part of another carrier's  
35 provider network; and

36 (iii) Application for a health benefit plan under that carrier's  
37 provider network individual coverage is made within ninety days of his  
38 or her provider leaving the previous carrier's provider network; then

1 completion of the standard health questionnaire shall not be a  
2 condition of coverage.

3 (2) If, based upon the results of the standard health  
4 questionnaire, the person qualifies for coverage under the Washington  
5 state health insurance pool, the following shall apply:

6 (a) The carrier may decide not to accept the person's application  
7 for enrollment in its individual health benefit plan; and

8 (b) Within fifteen business days of receipt of a completed  
9 application, the carrier shall provide written notice of the decision  
10 not to accept the person's application for enrollment to both the  
11 person and the administrator of the Washington state health insurance  
12 pool. The notice to the person shall state that the person is eligible  
13 for health insurance provided by the Washington state health insurance  
14 pool, and shall include information about the Washington state health  
15 insurance pool and an application for such coverage.

16 (3) If the person applying for an individual health benefit plan:

17 (a) Does not qualify for coverage under the Washington state health  
18 insurance pool based upon the results of the standard health  
19 questionnaire; (b) does qualify for coverage under the Washington state  
20 health insurance pool based upon the results of the standard health  
21 questionnaire and the carrier elects to accept the person for  
22 enrollment; or (c) is not required to complete the standard health  
23 questionnaire designated under this chapter under subsection (1)(a) or  
24 (b) of this section, the carrier shall accept the person for enrollment  
25 if he or she resides within the carrier's service area and provide or  
26 assure the provision of all covered services regardless of age, sex,  
27 family structure, ethnicity, race, health condition, geographic  
28 location, employment status, socioeconomic status, other condition or  
29 situation, or the provisions of RCW 49.60.174(2). The commissioner may  
30 grant a temporary exemption from this subsection if, upon application  
31 by a health carrier, the commissioner finds that the clinical,  
32 financial, or administrative capacity to serve existing enrollees will  
33 be impaired if a health carrier is required to continue enrollment of  
34 additional eligible individuals.

35 NEW SECTION. **Sec. 22.** A new section is added to chapter 48.43 RCW  
36 to read as follows:

37 Except as otherwise required by statute or rule, a carrier and the  
38 Washington state health insurance pool, and persons acting at the

1 direction of or on behalf of a carrier or the pool, who are in receipt  
2 of an enrollee's or applicant's personally identifiable health  
3 information included in the standard health questionnaire shall not  
4 disclose the identifiable health information unless such disclosure is  
5 explicitly authorized in writing by the person who is the subject of  
6 the information.

7 **Sec. 23.** RCW 48.43.025 and 1995 c 265 s 6 are each amended to read  
8 as follows:

9 (1) For group health benefit plans for groups other than small  
10 groups, no carrier may reject an individual for health plan coverage  
11 based upon preexisting conditions of the individual and no carrier may  
12 deny, exclude, or otherwise limit coverage for an individual's  
13 preexisting health conditions; except that a carrier may impose a  
14 three-month benefit waiting period for preexisting conditions for which  
15 medical advice was given, or for which a health care provider  
16 recommended or provided treatment, or for which a prudent layperson  
17 would have sought advice or treatment, within three months before the  
18 effective date of coverage. Any preexisting condition waiting period  
19 or limitation relating to pregnancy as a preexisting condition shall be  
20 imposed only to the extent allowed in the federal health insurance  
21 portability and accountability act of 1996.

22 (2) For group health benefit plans for small groups, no carrier may  
23 reject an individual for health plan coverage based upon preexisting  
24 conditions of the individual and no carrier may deny, exclude, or  
25 otherwise limit coverage for an individual's preexisting health  
26 conditions. Except that a carrier may impose a nine-month benefit  
27 waiting period for preexisting conditions for which medical advice was  
28 given, or for which a health care provider recommended or provided  
29 treatment, or for which a prudent layperson would have sought advice or  
30 treatment, within six months before the effective date of coverage.  
31 Any preexisting condition waiting period or limitation relating to  
32 pregnancy as a preexisting condition shall be imposed only to the  
33 extent allowed in the federal health insurance portability and  
34 accountability act of 1996.

35 (3) No carrier may avoid the requirements of this section through  
36 the creation of a new rate classification or the modification of an  
37 existing rate classification. A new or changed rate classification  
38 will be deemed an attempt to avoid the provisions of this section if

1 the new or changed classification would substantially discourage  
2 applications for coverage from individuals or groups who are higher  
3 than average health risks. These provisions apply only to individuals  
4 who are Washington residents.

5 **Sec. 24.** RCW 48.43.035 and 1995 c 265 s 7 are each amended to read  
6 as follows:

7 For group health benefit plans, the following shall apply:

8 (1) All health carriers shall accept for enrollment any state  
9 resident within the group to whom the plan is offered and within the  
10 carrier's service area and provide or assure the provision of all  
11 covered services regardless of age, sex, family structure, ethnicity,  
12 race, health condition, geographic location, employment status,  
13 socioeconomic status, other condition or situation, or the provisions  
14 of RCW 49.60.174(2). The insurance commissioner may grant a temporary  
15 exemption from this subsection, if, upon application by a health  
16 carrier the commissioner finds that the clinical, financial, or  
17 administrative capacity to serve existing enrollees will be impaired if  
18 a health carrier is required to continue enrollment of additional  
19 eligible individuals.

20 (2) Except as provided in subsection (5) of this section, all  
21 health plans shall contain or incorporate by endorsement a guarantee of  
22 the continuity of coverage of the plan. For the purposes of this  
23 section, a plan is "renewed" when it is continued beyond the earliest  
24 date upon which, at the carrier's sole option, the plan could have been  
25 terminated for other than nonpayment of premium. (~~In the case of~~  
26 ~~group plans,~~) The carrier may consider the group's anniversary date as  
27 the renewal date for purposes of complying with the provisions of this  
28 section.

29 (3) The guarantee of continuity of coverage required in health  
30 plans shall not prevent a carrier from canceling or nonrenewing a  
31 health plan for:

32 (a) Nonpayment of premium;

33 (b) Violation of published policies of the carrier approved by the  
34 insurance commissioner;

35 (c) Covered persons entitled to become eligible for medicare  
36 benefits by reason of age who fail to apply for a medicare supplement  
37 plan or medicare cost, risk, or other plan offered by the carrier  
38 pursuant to federal laws and regulations;

1 (d) Covered persons who fail to pay any deductible or copayment  
2 amount owed to the carrier and not the provider of health care  
3 services;

4 (e) Covered persons committing fraudulent acts as to the carrier;

5 (f) Covered persons who materially breach the health plan; or

6 (g) Change or implementation of federal or state laws that no  
7 longer permit the continued offering of such coverage.

8 (4) The provisions of this section do not apply in the following  
9 cases:

10 (a) A carrier has zero enrollment on a product; or

11 (b) A carrier replaces a product and the replacement product is  
12 provided to all covered persons within that class or line of business,  
13 includes all of the services covered under the replaced product, and  
14 does not significantly limit access to the kind of services covered  
15 under the replaced product. The health plan may also allow  
16 unrestricted conversion to a fully comparable product; or

17 (c) A carrier is withdrawing from a service area or from a segment  
18 of its service area because the carrier has demonstrated to the  
19 insurance commissioner that the carrier's clinical, financial, or  
20 administrative capacity to serve enrollees would be exceeded.

21 (5) The provisions of this section do not apply to health plans  
22 deemed by the insurance commissioner to be unique or limited or have a  
23 short-term purpose, after a written request for such classification by  
24 the carrier and subsequent written approval by the insurance  
25 commissioner.

26 NEW SECTION. **Sec. 25.** A new section is added to chapter 48.43 RCW  
27 to read as follows:

28 (1) Except as provided in subsection (4) of this section, all  
29 individual health plans shall contain or incorporate by endorsement a  
30 guarantee of the continuity of coverage of the plan. For the purposes  
31 of this section, a plan is "renewed" when it is continued beyond the  
32 earliest date upon which, at the carrier's sole option, the plan could  
33 have been terminated for other than nonpayment of premium.

34 (2) The guarantee of continuity of coverage required in individual  
35 health plans shall not prevent a carrier from canceling or nonrenewing  
36 a health plan for:

37 (a) Nonpayment of premium;

1 (b) Violation of published policies of the carrier approved by the  
2 commissioner;

3 (c) Covered persons entitled to become eligible for medicare  
4 benefits by reason of age who fail to apply for a medicare supplement  
5 plan or medicare cost, risk, or other plan offered by the carrier  
6 pursuant to federal laws and regulations;

7 (d) Covered persons who fail to pay any deductible or copayment  
8 amount owed to the carrier and not the provider of health care  
9 services;

10 (e) Covered persons committing fraudulent acts as to the carrier;

11 (f) Covered persons who materially breach the health plan; or

12 (g) Change or implementation of federal or state laws that no  
13 longer permit the continued offering of such coverage.

14 (3) This section does not apply in the following cases:

15 (a) A carrier has zero enrollment on a product;

16 (b) A carrier is withdrawing from a service area or from a segment  
17 of its service area because the carrier has demonstrated to the  
18 commissioner that the carrier's clinical, financial, or administrative  
19 capacity to serve enrollees would be exceeded;

20 (c) No sooner than the first day of the month following the  
21 expiration of a one hundred eighty-day period beginning on the  
22 effective date of this section, a carrier discontinues offering a  
23 particular type of health benefit plan offered in the individual market  
24 if: (i) The carrier provides notice to each covered individual  
25 provided coverage of this type of such discontinuation at least ninety  
26 days prior to the date of the discontinuation; (ii) the carrier offers  
27 to each individual provided coverage of this type the option, without  
28 being subject to the standard health questionnaire, to enroll in any  
29 other individual health benefit plan currently being offered by the  
30 carrier; and (iii) in exercising the option to discontinue coverage of  
31 this type and in offering the option of coverage under (c)(ii) of this  
32 subsection, the carrier acts uniformly without regard to any health  
33 status-related factor of enrolled individuals or individuals who may  
34 become eligible for such coverage; or

35 (d) A carrier discontinues offering all individual health coverage  
36 in the state and discontinues coverage under all existing individual  
37 health benefit plans if: (i) The carrier provides notice to the  
38 commissioner of its intent to discontinue offering all individual  
39 health coverage in the state and its intent to discontinue coverage

1 under all existing health benefit plans at least one hundred eighty  
2 days prior to the date of the discontinuation of coverage under all  
3 existing health benefit plans; and (ii) the carrier provides notice to  
4 each covered individual of the intent to discontinue his or her  
5 existing health benefit plan at least one hundred eighty days prior to  
6 the date of such discontinuation. In the case of discontinuation under  
7 this subsection, the carrier may not issue any individual health  
8 coverage in this state for a five-year period beginning on the date of  
9 the discontinuation of the last health plan not so renewed. Nothing in  
10 this subsection (3) shall be construed to require a carrier to provide  
11 notice to the commissioner of its intent to discontinue offering a  
12 health benefit plan to new applicants where the carrier does not  
13 discontinue coverage of existing enrollees under that health benefit  
14 plan.

15 (4) The provisions of this section do not apply to health plans  
16 deemed by the commissioner to be unique or limited or have a short-term  
17 purpose, after a written request for such classification by the carrier  
18 and subsequent written approval by the commissioner.

19 NEW SECTION. **Sec. 26.** A new section is added to chapter 48.43 RCW  
20 to read as follows:

21 (1) All individual health benefit plans, other than catastrophic  
22 health plans, offered or renewed on or after the effective date of this  
23 section, shall include benefits described in this section. Nothing in  
24 this section shall be construed to require a carrier to offer an  
25 individual health benefit plan.

26 (a) Maternity services that include, with no enrollee cost-sharing  
27 requirements beyond those generally applicable cost-sharing  
28 requirements: Diagnosis of pregnancy; prenatal care; delivery; care  
29 for complications of pregnancy; physician services; hospital services;  
30 operating or other special procedure rooms; radiology and laboratory  
31 services; appropriate medications; anesthesia; and services required  
32 under RCW 48.43.115; and

33 (b) Prescription drug benefits with at least a two thousand dollar  
34 benefit payable by the carrier annually.

35 (2) If a carrier offers a health benefit plan that is not a  
36 catastrophic health plan to groups, and it chooses to offer a health  
37 benefit plan to individuals, it must offer at least one health benefit  
38 plan to individuals that is not a catastrophic health plan.

1        NEW SECTION.    **Sec. 27.**    A new section is added to chapter 48.46 RCW  
2 to read as follows:

3        Notwithstanding the provisions of this chapter, a health  
4 maintenance organization may offer catastrophic health plans as defined  
5 in RCW 48.43.005.

6        **Sec. 28.**    RCW 48.44.020 and 1990 c 120 s 5 are each amended to read  
7 as follows:

8        (1) Any health care service contractor may enter into contracts  
9 with or for the benefit of persons or groups of persons which require  
10 prepayment for health care services by or for such persons in  
11 consideration of such health care service contractor providing one or  
12 more health care services to such persons and such activity shall not  
13 be subject to the laws relating to insurance if the health care  
14 services are rendered by the health care service contractor or by a  
15 participating provider.

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

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

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

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

28        (d) ~~((If, the benefits provided therein are unreasonable in  
29 relation to the amount charged for the contract;~~

30        ~~(e))~~ If it contains unreasonable restrictions on the treatment of  
31 patients; or

32        ~~((f))~~ (e) If it violates any provision of this chapter; or

33        ~~((g))~~ (f) If it fails to conform to minimum provisions or  
34 standards required by regulation made by the commissioner pursuant to  
35 chapter 34.05 RCW; or

36        ~~((h))~~ (g) If any contract for health care services with any state  
37 agency, division, subdivision, board, or commission or with any

1 political subdivision, municipal corporation, or quasi-municipal  
2 corporation fails to comply with state law.

3 (3) In addition to the grounds listed in subsection (2) of this  
4 section, the commissioner may disapprove any group contract if the  
5 benefits provided therein are unreasonable in relation to the amount  
6 charged for the contract.

7 (4)(a) Every contract between a health care service contractor and  
8 a participating provider of health care services shall be in writing  
9 and shall state that in the event the health care service contractor  
10 fails to pay for health care services as provided in the contract, the  
11 enrolled participant shall not be liable to the provider for sums owed  
12 by the health care service contractor. Every such contract shall  
13 provide that this requirement shall survive termination of the  
14 contract.

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

18 NEW SECTION. Sec. 29. A new section is added to chapter 48.44 RCW  
19 to read as follows:

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

22 (a) "Claims" means the cost to the health care service contractor  
23 of health care services, as defined in RCW 48.43.005, provided to a  
24 contract holder or paid to or on behalf of a contract holder in  
25 accordance with the terms of a health benefit plan, as defined in RCW  
26 48.43.005. This includes capitation payments or other similar payments  
27 made to providers for the purpose of paying for health care services  
28 for an enrollee.

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

34 (c) "Earned premiums" means premiums, as defined in RCW 48.43.005,  
35 plus any rate credits or recouplements less any refunds, for the  
36 applicable period, whether received before, during, or after the  
37 applicable period.

1 (d) "Incurred claims expense" means claims paid during the  
2 applicable period plus any increase, or less any decrease, in the  
3 claims reserves.

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

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

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

11 (3) A health care service contractor shall file with the notice  
12 required under subsection (2) of this section supporting documentation  
13 of its method of determining the rates charged. The commissioner may  
14 request only the following supporting documentation:

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

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

20 (c) The percentage of premium attributable in aggregate for  
21 nonclaims expenses used to determine the adjusted community rates  
22 charged; and

23 (d) A certification by a member of the American academy of  
24 actuaries, or other person approved by the commissioner, that the  
25 adjusted community rate charged can be reasonably expected to result in  
26 a loss ratio that meets or exceeds the loss ratio standard established  
27 in subsection (7) of this section.

28 (4) The commissioner may not disapprove or otherwise impede the  
29 implementation of the filed rates.

30 (5) By the last day of May each year any health care service  
31 contractor providing individual health benefit plans in this state  
32 shall file for review by the commissioner supporting documentation of  
33 its actual loss ratio for its individual health benefit plans offered  
34 in this state in aggregate for the preceding calendar year. The filing  
35 shall include a certification by a member of the American academy of  
36 actuaries, or other person approved by the commissioner, that the  
37 actual loss ratio has been calculated in accordance with accepted  
38 actuarial principles.

1 (a) At the expiration of a thirty-day period beginning with the  
2 date the filing is delivered to the commissioner, the filing shall be  
3 deemed approved unless prior thereto the commissioner contests the  
4 calculation of the actual loss ratio.

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

8 (c) Any dispute regarding the calculation of the actual loss ratio  
9 shall upon written demand of either the commissioner or the health care  
10 service contractor be submitted to hearing under chapters 48.04 and  
11 34.05 RCW.

12 (6) If the actual loss ratio for the preceding calendar year is  
13 less than the loss ratio standard established in subsection (7) of this  
14 section, a remittance is due and the following shall apply:

15 (a) The health care service contractor shall calculate a percentage  
16 of premium to be remitted to the Washington state health insurance pool  
17 by subtracting the actual loss ratio for the preceding year from the  
18 loss ratio established in subsection (7) of this section.

19 (b) The remittance to the Washington state health insurance pool is  
20 the percentage calculated in (a) of this subsection, multiplied by the  
21 premium earned from each enrollee in the previous calendar year.  
22 Interest shall be added to the remittance due at a five percent annual  
23 rate calculated from the end of the calendar year for which the  
24 remittance is due to the date the remittance is made.

25 (c) All remittances shall be aggregated and such amounts shall be  
26 remitted to the Washington state high risk pool to be used as directed  
27 by the pool board of directors.

28 (d) Any remittance required to be issued under this section shall  
29 be issued within thirty days after the actual loss ratio is deemed  
30 approved under subsection (5)(a) of this section or the determination  
31 by an administrative law judge under subsection (5)(c) of this section.

32 (7) The loss ratio applicable to this section shall be seventy-four  
33 percent minus the premium tax rate applicable to the health care  
34 service contractor's individual health benefit plans under RCW  
35 48.14.0201.

36 **Sec. 30.** RCW 48.44.022 and 1997 c 231 s 208 are each amended to  
37 read as follows:

1       ~~(1)((a) A health care service contractor offering any health~~  
2 ~~benefit plan to any individual shall offer and actively market to all~~  
3 ~~individuals a health benefit plan providing benefits identical to the~~  
4 ~~schedule of covered health benefits that are required to be delivered~~  
5 ~~to an individual enrolled in the basic health plan, subject to the~~  
6 ~~provisions in RCW 48.43.025 and 48.43.035. Nothing in this subsection~~  
7 ~~shall preclude a contractor from offering, or an individual from~~  
8 ~~purchasing, other health benefit plans that may have more or less~~  
9 ~~comprehensive benefits than the basic health plan, provided such plans~~  
10 ~~are in accordance with this chapter. A contractor offering a health~~  
11 ~~benefit plan that does not include benefits provided in the basic~~  
12 ~~health plan shall clearly disclose these differences to the individual~~  
13 ~~in a brochure approved by the commissioner.~~

14       ~~(b) A health benefit plan shall provide coverage for hospital~~  
15 ~~expenses and services rendered by a physician licensed under chapter~~  
16 ~~18.57 or 18.71 RCW but is not subject to the requirements of RCW~~  
17 ~~48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310,~~  
18 ~~48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344,~~  
19 ~~48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if the health~~  
20 ~~benefit plan is the mandatory offering under (a) of this subsection~~  
21 ~~that provides benefits identical to the basic health plan, to the~~  
22 ~~extent these requirements differ from the basic health plan.~~

23       ~~(2)) Premium rates for health benefit plans for individuals shall~~  
24 ~~be subject to the following provisions:~~

25       ~~(a) The health care service contractor shall develop its rates~~  
26 ~~based on an adjusted community rate and may only vary the adjusted~~  
27 ~~community rate for:~~

- 28       ~~(i) Geographic area;~~
- 29       ~~(ii) Family size;~~
- 30       ~~(iii) Age;~~
- 31       ~~(iv) Tenure discounts; and~~
- 32       ~~(v) Wellness activities.~~

33       ~~(b) The adjustment for age in (a)(iii) of this subsection may not~~  
34 ~~use age brackets smaller than five-year increments which shall begin~~  
35 ~~with age twenty and end with age sixty-five. Individuals under the age~~  
36 ~~of twenty shall be treated as those age twenty.~~

37       ~~(c) The health care service contractor shall be permitted to~~  
38 ~~develop separate rates for individuals age sixty-five or older for~~  
39 ~~coverage for which medicare is the primary payer and coverage for which~~

1 medicare is not the primary payer. Both rates shall be subject to the  
2 requirements of this subsection.

3 (d) The permitted rates for any age group shall be no more than  
4 four hundred twenty-five percent of the lowest rate for all age groups  
5 on January 1, 1996, four hundred percent on January 1, 1997, and three  
6 hundred seventy-five percent on January 1, 2000, and thereafter.

7 (e) A discount for wellness activities shall be permitted to  
8 reflect actuarially justified differences in utilization or cost  
9 attributed to such programs not to exceed twenty percent.

10 (f) The rate charged for a health benefit plan offered under this  
11 section may not be adjusted more frequently than annually except that  
12 the premium may be changed to reflect:

13 (i) Changes to the family composition;

14 (ii) Changes to the health benefit plan requested by the  
15 individual; or

16 (iii) Changes in government requirements affecting the health  
17 benefit plan.

18 (g) For the purposes of this section, a health benefit plan that  
19 contains a restricted network provision shall not be considered similar  
20 coverage to a health benefit plan that does not contain such a  
21 provision, provided that the restrictions of benefits to network  
22 providers result in substantial differences in claims costs. This  
23 subsection does not restrict or enhance the portability of benefits as  
24 provided in RCW 48.43.015.

25 (h) A tenure discount for continuous enrollment in the health plan  
26 of two years or more may be offered, not to exceed ten percent.

27 ~~((+3))~~ (2) Adjusted community rates established under this section  
28 shall pool the medical experience of all individuals purchasing  
29 coverage, and shall not be required to be pooled with the medical  
30 experience of health benefit plans offered to small employers under RCW  
31 48.44.023.

32 ~~((+4))~~ (3) As used in this section and RCW 48.44.023 "health  
33 benefit plan," "small employer," ~~(("basic health plan,"))~~ "adjusted  
34 community rates," and "wellness activities" mean the same as defined in  
35 RCW 48.43.005.

36 **Sec. 31.** RCW 48.46.060 and 1989 c 10 s 10 are each amended to read  
37 as follows:

1 (1) Any health maintenance organization may enter into agreements  
2 with or for the benefit of persons or groups of persons, which require  
3 prepayment for health care services by or for such persons in  
4 consideration of the health maintenance organization providing health  
5 care services to such persons. Such activity is not subject to the  
6 laws relating to insurance if the health care services are rendered  
7 directly by the health maintenance organization or by any provider  
8 which has a contract or other arrangement with the health maintenance  
9 organization to render health services to enrolled participants.

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

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

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

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

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

32 ~~((If the benefits provided therein are unreasonable in relation  
33 to the amount charged for the agreement;~~

34 ~~(e)))~~ If it contains unreasonable restrictions on the treatment of  
35 patients;

36 ~~((f)))~~ (e) If it is in any respect in violation of this chapter or  
37 if it fails to conform to minimum provisions or standards required by  
38 the commissioner by rule under chapter 34.05 RCW; or

1       (~~(g)~~) (f) If any agreement for health care services with any  
2 state agency, division, subdivision, board, or commission or with any  
3 political subdivision, municipal corporation, or quasi-municipal  
4 corporation fails to comply with state law.

5       (4) In addition to the grounds listed in subsection (2) of this  
6 section, the commissioner may disapprove any group agreement if the  
7 benefits provided therein are unreasonable in relation to the amount  
8 charged for the agreement.

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

23       (~~(5)~~) (6) No agreement form or amendment to an approved agreement  
24 form shall be used unless it is first filed with the commissioner.

25       NEW SECTION. Sec. 32. A new section is added to chapter 48.46 RCW  
26 to read as follows:

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

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

36       (b) "Claims reserves" means: (i) The liability for claims which  
37 have been reported but not paid; (ii) the liability for claims which  
38 have not been reported but which may reasonably be expected; (iii)

1 active life reserves; and (iv) additional claims reserves whether for  
2 a specific liability purpose or not.

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

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

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

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

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

17 (3) A health maintenance organization shall file with the notice  
18 required under subsection (2) of this section supporting documentation  
19 of its method of determining the rates charged. The commissioner may  
20 request only the following supporting documentation:

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

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

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

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

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

36 (5) By the last day of May each year any health maintenance  
37 organization providing individual health benefit plans in this state  
38 shall file for review by the commissioner supporting documentation of  
39 its actual loss ratio for its individual health benefit plans offered

1 in the state in aggregate for the preceding calendar year. The filing  
2 shall include a certification by a member of the American academy of  
3 actuaries, or other person approved by the commissioner, that the  
4 actual loss ratio has been calculated in accordance with accepted  
5 actuarial principles.

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

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

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

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

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

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

30 (c) All remittances shall be aggregated and such amounts shall be  
31 remitted to the Washington state high risk pool to be used as directed  
32 by the pool board of directors.

33 (d) Any remittance required to be issued under this section shall  
34 be issued within thirty days after the actual loss ratio is deemed  
35 approved under subsection (5)(a) of this section or the determination  
36 by an administrative law judge under subsection (5)(c) of this section.

37 (7) The loss ratio applicable to this section shall be seventy-four  
38 percent minus the premium tax rate applicable to the health maintenance  
39 organization's individual health benefit plans under RCW 48.14.0201.

1       **Sec. 33.** RCW 48.46.064 and 1997 c 231 s 209 are each amended to  
2 read as follows:

3       ~~(1)((a) A health maintenance organization offering any health~~  
4 ~~benefit plan to any individual shall offer and actively market to all~~  
5 ~~individuals a health benefit plan providing benefits identical to the~~  
6 ~~schedule of covered health benefits that are required to be delivered~~  
7 ~~to an individual enrolled in the basic health plan, subject to the~~  
8 ~~provisions in RCW 48.43.025 and 48.43.035. Nothing in this subsection~~  
9 ~~shall preclude a health maintenance organization from offering, or an~~  
10 ~~individual from purchasing, other health benefit plans that may have~~  
11 ~~more or less comprehensive benefits than the basic health plan,~~  
12 ~~provided such plans are in accordance with this chapter. A health~~  
13 ~~maintenance organization offering a health benefit plan that does not~~  
14 ~~include benefits provided in the basic health plan shall clearly~~  
15 ~~disclose these differences to the individual in a brochure approved by~~  
16 ~~the commissioner.~~

17       ~~(b) A health benefit plan shall provide coverage for hospital~~  
18 ~~expenses and services rendered by a physician licensed under chapter~~  
19 ~~18.57 or 18.71 RCW but is not subject to the requirements of RCW~~  
20 ~~48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355,~~  
21 ~~48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if~~  
22 ~~the health benefit plan is the mandatory offering under (a) of this~~  
23 ~~subsection that provides benefits identical to the basic health plan,~~  
24 ~~to the extent these requirements differ from the basic health plan.~~

25       ~~(2))~~ Premium rates for health benefit plans for individuals shall  
26 be subject to the following provisions:

27       (a) The health maintenance organization shall develop its rates  
28 based on an adjusted community rate and may only vary the adjusted  
29 community rate for:

- 30       (i) Geographic area;
- 31       (ii) Family size;
- 32       (iii) Age;
- 33       (iv) Tenure discounts; and
- 34       (v) Wellness activities.

35       (b) The adjustment for age in (a)(iii) of this subsection may not  
36 use age brackets smaller than five-year increments which shall begin  
37 with age twenty and end with age sixty-five. Individuals under the age  
38 of twenty shall be treated as those age twenty.

1 (c) The health maintenance organization shall be permitted to  
2 develop separate rates for individuals age sixty-five or older for  
3 coverage for which medicare is the primary payer and coverage for which  
4 medicare is not the primary payer. Both rates shall be subject to the  
5 requirements of this subsection.

6 (d) The permitted rates for any age group shall be no more than  
7 four hundred twenty-five percent of the lowest rate for all age groups  
8 on January 1, 1996, four hundred percent on January 1, 1997, and three  
9 hundred seventy-five percent on January 1, 2000, and thereafter.

10 (e) A discount for wellness activities shall be permitted to  
11 reflect actuarially justified differences in utilization or cost  
12 attributed to such programs not to exceed twenty percent.

13 (f) The rate charged for a health benefit plan offered under this  
14 section may not be adjusted more frequently than annually except that  
15 the premium may be changed to reflect:

16 (i) Changes to the family composition;

17 (ii) Changes to the health benefit plan requested by the  
18 individual; or

19 (iii) Changes in government requirements affecting the health  
20 benefit plan.

21 (g) For the purposes of this section, a health benefit plan that  
22 contains a restricted network provision shall not be considered similar  
23 coverage to a health benefit plan that does not contain such a  
24 provision, provided that the restrictions of benefits to network  
25 providers result in substantial differences in claims costs. This  
26 subsection does not restrict or enhance the portability of benefits as  
27 provided in RCW 48.43.015.

28 (h) A tenure discount for continuous enrollment in the health plan  
29 of two years or more may be offered, not to exceed ten percent.

30 ~~((+3))~~ (2) Adjusted community rates established under this section  
31 shall pool the medical experience of all individuals purchasing  
32 coverage, and shall not be required to be pooled with the medical  
33 experience of health benefit plans offered to small employers under RCW  
34 48.46.066.

35 ~~((+4))~~ (3) As used in this section and RCW 48.46.066, "health  
36 benefit plan," (~~("basic health plan,"~~) "adjusted community rate,"  
37 "small employer," and "wellness activities" mean the same as defined in  
38 RCW 48.43.005.

1       **Sec. 34.** RCW 70.47.060 and 1998 c 314 s 17 and 1998 c 148 s 1 are  
2 each reenacted and amended to read as follows:

3       The administrator has the following powers and duties:

4       (1) To design and from time to time revise a schedule of covered  
5 basic health care services, including physician services, inpatient and  
6 outpatient hospital services, prescription drugs and medications, and  
7 other services that may be necessary for basic health care. In  
8 addition, the administrator may, to the extent that funds are  
9 available, offer as basic health plan services chemical dependency  
10 services, mental health services and organ transplant services;  
11 however, no one service or any combination of these three services  
12 shall increase the actuarial value of the basic health plan benefits by  
13 more than five percent excluding inflation, as determined by the office  
14 of financial management. All subsidized and nonsubsidized enrollees in  
15 any participating managed health care system under the Washington basic  
16 health plan shall be entitled to receive covered basic health care  
17 services in return for premium payments to the plan. The schedule of  
18 services shall emphasize proven preventive and primary health care and  
19 shall include all services necessary for prenatal, postnatal, and well-  
20 child care. However, with respect to coverage for ~~((groups of))~~  
21 subsidized enrollees who are eligible to receive prenatal and postnatal  
22 services through the medical assistance program under chapter 74.09  
23 RCW, the administrator shall not contract for such services except to  
24 the extent that such services are necessary over not more than a one-  
25 month period in order to maintain continuity of care after diagnosis of  
26 pregnancy by the managed care provider. The schedule of services shall  
27 also include a separate schedule of basic health care services for  
28 children, eighteen years of age and younger, for those subsidized or  
29 nonsubsidized enrollees who choose to secure basic coverage through the  
30 plan only for their dependent children. In designing and revising the  
31 schedule of services, the administrator shall consider the guidelines  
32 for assessing health services under the mandated benefits act of 1984,  
33 RCW 48.47.030, and such other factors as the administrator deems  
34 appropriate.

35       ~~((However, with respect to coverage for subsidized enrollees who  
36 are eligible to receive prenatal and postnatal services through the  
37 medical assistance program under chapter 74.09 RCW, the administrator  
38 shall not contract for such services except to the extent that the  
39 services are necessary over not more than a one month period in order~~

1 ~~to maintain continuity of care after diagnosis of pregnancy by the~~  
2 ~~managed care provider.))~~

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

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

19 (c) An employer or other financial sponsor may, with the prior  
20 approval of the administrator, pay the premium, rate, or any other  
21 amount on behalf of a subsidized or nonsubsidized enrollee, by  
22 arrangement with the enrollee and through a mechanism acceptable to the  
23 administrator.

24 ~~((d) To develop, as an offering by every health carrier providing~~  
25 ~~coverage identical to the basic health plan, as configured on January~~  
26 ~~1, 1996, a basic health plan model plan with uniformity in enrollee~~  
27 ~~cost-sharing requirements.))~~

28 (3) To design and implement a structure of enrollee cost-sharing  
29 due a managed health care system from subsidized and nonsubsidized  
30 enrollees. The structure shall discourage inappropriate enrollee  
31 utilization of health care services, and may utilize copayments,  
32 deductibles, and other cost-sharing mechanisms, but shall not be so  
33 costly to enrollees as to constitute a barrier to appropriate  
34 utilization of necessary health care services.

35 (4) To limit enrollment of persons who qualify for subsidies so as  
36 to prevent an overexpenditure of appropriations for such purposes.  
37 Whenever the administrator finds that there is danger of such an  
38 overexpenditure, the administrator shall close enrollment until the  
39 administrator finds the danger no longer exists.

1 (5) To limit the payment of subsidies to subsidized enrollees, as  
2 defined in RCW 70.47.020. The level of subsidy provided to persons who  
3 qualify may be based on the lowest cost plans, as defined by the  
4 administrator.

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

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

27 (8) To receive periodic premiums from or on behalf of subsidized  
28 and nonsubsidized enrollees, deposit them in the basic health plan  
29 operating account, keep records of enrollee status, and authorize  
30 periodic payments to managed health care systems on the basis of the  
31 number of enrollees participating in the respective managed health care  
32 systems.

33 (9) To accept applications from individuals residing in areas  
34 served by the plan, on behalf of themselves and their spouses and  
35 dependent children, for enrollment in the Washington basic health plan  
36 as subsidized or nonsubsidized enrollees, to establish appropriate  
37 minimum-enrollment periods for enrollees as may be necessary, and to  
38 determine, upon application and on a reasonable schedule defined by the  
39 authority, or at the request of any enrollee, eligibility due to

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

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

38 (11) To determine the rate to be paid to each participating managed  
39 health care system in return for the provision of covered basic health

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

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

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

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

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

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

36 (17) To administer the premium discounts provided under RCW  
37 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington  
38 state health insurance pool.

1       **Sec. 35.** RCW 70.47.100 and 1987 1st ex.s. c 5 s 12 are each  
2 amended to read as follows:

3       (1) A managed health care ((systems)) system participating in the  
4 plan shall do so by contract with the administrator and shall provide,  
5 directly or by contract with other health care providers, covered basic  
6 health care services to each enrollee covered by its contract with the  
7 administrator as long as payments from the administrator on behalf of  
8 the enrollee are current. A participating managed health care system  
9 may offer, without additional cost, health care benefits or services  
10 not included in the schedule of covered services under the plan. A  
11 participating managed health care system shall not give preference in  
12 enrollment to enrollees who accept such additional health care benefits  
13 or services. Managed health care systems participating in the plan  
14 shall not discriminate against any potential or current enrollee based  
15 upon health status, sex, race, ethnicity, or religion. The  
16 administrator may receive and act upon complaints from enrollees  
17 regarding failure to provide covered services or efforts to obtain  
18 payment, other than authorized copayments, for covered services  
19 directly from enrollees, but nothing in this chapter empowers the  
20 administrator to impose any sanctions under Title 18 RCW or any other  
21 professional or facility licensing statute.

22       (2) The plan shall allow, at least annually, an opportunity for  
23 enrollees to transfer their enrollments among participating managed  
24 health care systems serving their respective areas. The administrator  
25 shall establish a period of at least twenty days in a given year when  
26 this opportunity is afforded enrollees, and in those areas served by  
27 more than one participating managed health care system the  
28 administrator shall endeavor to establish a uniform period for such  
29 opportunity. The plan shall allow enrollees to transfer their  
30 enrollment to another participating managed health care system at any  
31 time upon a showing of good cause for the transfer.

32       (~~Any contract between a hospital and a participating managed~~  
33 ~~health care system under this chapter is subject to the requirements of~~  
34 ~~RCW 70.39.140(1) regarding negotiated rates.))~~

35       (3) Prior to negotiating with any managed health care system, the  
36 administrator shall determine, on an actuarially sound basis, the  
37 reasonable cost of providing the schedule of basic health care  
38 services, expressed in terms of upper and lower limits, and recognizing

1 variations in the cost of providing the services through the various  
2 systems and in different areas of the state.

3 (4) In negotiating with managed health care systems for  
4 participation in the plan, the administrator shall adopt a uniform  
5 procedure that includes at least the following:

6 ((+1)) (a) The administrator shall issue a request for proposals,  
7 including standards regarding the quality of services to be provided;  
8 financial integrity of the responding systems; and responsiveness to  
9 the unmet health care needs of the local communities or populations  
10 that may be served;

11 ((+2)) (b) The administrator shall then review responsive  
12 proposals and may negotiate with respondents to the extent necessary to  
13 refine any proposals;

14 ((+3)) (c) The administrator may then select one or more systems  
15 to provide the covered services within a local area; and

16 ((+4)) (d) The administrator may adopt a policy that gives  
17 preference to respondents, such as nonprofit community health clinics,  
18 that have a history of providing quality health care services to low-  
19 income persons.

20 (5) The administrator may contract with a managed health care  
21 system to provide covered basic health care services to either  
22 subsidized enrollees, or nonsubsidized enrollees, or both.

23 (6) The administrator may establish procedures and policies to  
24 further negotiate and contract with managed health care systems  
25 following completion of the request for proposal process in subsection  
26 (4) of this section, upon a determination by the administrator that it  
27 is necessary to provide access, as defined in the request for proposal  
28 documents, to covered basic health care services for enrollees.

29 (7)(a) The administrator shall implement a self-funded or self-  
30 insured method of providing insurance coverage to subsidized enrollees,  
31 as provided under RCW 41.05.140, if one of the following conditions is  
32 met:

33 (i) The authority determines that no managed health care system  
34 other than the authority is willing and able to provide access, as  
35 defined in the request for proposal documents, to covered basic health  
36 care services for all subsidized enrollees in an area; or

37 (ii) The authority determines that no other managed health care  
38 system is willing to provide access, as defined in the request for  
39 proposal documents, for one hundred thirty-three percent of the state-

1 wide benchmark price or less, and the authority is able to offer such  
2 coverage at a price that is less than the lowest price at which any  
3 other managed health care system is willing to provide such access in  
4 an area.

5 (b) The authority shall initiate steps to provide the coverage  
6 described in (a) of this subsection within ninety days of making its  
7 determination that the conditions for providing a self-funded or self-  
8 insured method of providing insurance have been met.

9 (c) The administrator may not implement a self-funded or self-  
10 insured method of providing insurance in an area unless the  
11 administrator has received a certification from a member of the  
12 American academy of actuaries that the funding available in the basic  
13 health plan self-insurance reserve account is sufficient for the self-  
14 funded or self-insured risk assumed, or expected to be assumed, by the  
15 administrator.

16 NEW SECTION. Sec. 36. A new section is added to chapter 48.41 RCW  
17 to read as follows:

18 The Washington state health insurance pool account is created in  
19 the custody of the state treasurer. All receipts from moneys  
20 specifically appropriated to the account must be deposited in the  
21 account. Expenditures from this account shall be used to cover  
22 deficits incurred by the Washington state health insurance pool under  
23 this chapter in excess of the threshold established in this section.  
24 To the extent funds are available in the account, funds shall be  
25 expended from the account to offset that portion of the deficit that  
26 would otherwise have to be recovered by imposing an assessment on  
27 members in excess of a threshold of seventy cents per insured person  
28 per month. The commissioner shall authorize expenditures from the  
29 account, to the extent that funds are available in the account, upon  
30 certification by the pool board that assessments will exceed the  
31 threshold level established in this section. The account is subject to  
32 the allotment procedures under chapter 43.88 RCW, but an appropriation  
33 is not required for expenditures.

34 **Sec. 37.** RCW 43.84.092 and 1999 c 380 s 8, 1999 c 309 s 928, 1999  
35 c 268 s 4, and 1999 c 94 s 2 are each reenacted and amended to read as  
36 follows:

1 (1) All earnings of investments of surplus balances in the state  
2 treasury shall be deposited to the treasury income account, which  
3 account is hereby established in the state treasury.

4 (2) The treasury income account shall be utilized to pay or receive  
5 funds associated with federal programs as required by the federal cash  
6 management improvement act of 1990. The treasury income account is  
7 subject in all respects to chapter 43.88 RCW, but no appropriation is  
8 required for refunds or allocations of interest earnings required by  
9 the cash management improvement act. Refunds of interest to the  
10 federal treasury required under the cash management improvement act  
11 fall under RCW 43.88.180 and shall not require appropriation. The  
12 office of financial management shall determine the amounts due to or  
13 from the federal government pursuant to the cash management improvement  
14 act. The office of financial management may direct transfers of funds  
15 between accounts as deemed necessary to implement the provisions of the  
16 cash management improvement act, and this subsection. Refunds or  
17 allocations shall occur prior to the distributions of earnings set  
18 forth in subsection (4) of this section.

19 (3) Except for the provisions of RCW 43.84.160, the treasury income  
20 account may be utilized for the payment of purchased banking services  
21 on behalf of treasury funds including, but not limited to, depository,  
22 safekeeping, and disbursement functions for the state treasury and  
23 affected state agencies. The treasury income account is subject in all  
24 respects to chapter 43.88 RCW, but no appropriation is required for  
25 payments to financial institutions. Payments shall occur prior to  
26 distribution of earnings set forth in subsection (4) of this section.

27 (4) Monthly, the state treasurer shall distribute the earnings  
28 credited to the treasury income account. The state treasurer shall  
29 credit the general fund with all the earnings credited to the treasury  
30 income account except:

31 (a) The following accounts and funds shall receive their  
32 proportionate share of earnings based upon each account's and fund's  
33 average daily balance for the period: The capitol building  
34 construction account, the Cedar River channel construction and  
35 operation account, the Central Washington University capital projects  
36 account, the charitable, educational, penal and reformatory  
37 institutions account, the common school construction fund, the county  
38 criminal justice assistance account, the county sales and use tax  
39 equalization account, the data processing building construction

1 account, the deferred compensation administrative account, the deferred  
2 compensation principal account, the department of retirement systems  
3 expense account, the drinking water assistance account, the Eastern  
4 Washington University capital projects account, the education  
5 construction fund, the emergency reserve fund, the federal forest  
6 revolving account, the health services account, the public health  
7 services account, the health system capacity account, the personal  
8 health services account, the state higher education construction  
9 account, the higher education construction account, the highway  
10 infrastructure account, the industrial insurance premium refund  
11 account, the judges' retirement account, the judicial retirement  
12 administrative account, the judicial retirement principal account, the  
13 local leasehold excise tax account, the local real estate excise tax  
14 account, the local sales and use tax account, the medical aid account,  
15 the mobile home park relocation fund, the municipal criminal justice  
16 assistance account, the municipal sales and use tax equalization  
17 account, the natural resources deposit account, the perpetual  
18 surveillance and maintenance account, the public employees' retirement  
19 system plan 1 account, the public employees' retirement system plan 2  
20 account, the Puyallup tribal settlement account, the resource  
21 management cost account, the site closure account, the special wildlife  
22 account, the state employees' insurance account, the state employees'  
23 insurance reserve account, the state investment board expense account,  
24 the state investment board commingled trust fund accounts, the  
25 supplemental pension account, the teachers' retirement system plan 1  
26 account, the teachers' retirement system plan 2 account, the tobacco  
27 prevention and control account, the tobacco settlement account, the  
28 transportation infrastructure account, the tuition recovery trust fund,  
29 the University of Washington bond retirement fund, the University of  
30 Washington building account, the volunteer fire fighters' and reserve  
31 officers' relief and pension principal ((account)) fund, the volunteer  
32 fire fighters' ((relief and pension)) and reserve officers'  
33 administrative ((account)) fund, the Washington judicial retirement  
34 system account, the Washington law enforcement officers' and fire  
35 fighters' system plan 1 retirement account, the Washington law  
36 enforcement officers' and fire fighters' system plan 2 retirement  
37 account, the Washington state health insurance pool account, the  
38 Washington state patrol retirement account, the Washington State  
39 University building account, the Washington State University bond

1 retirement fund, the water pollution control revolving fund, and the  
2 Western Washington University capital projects account. Earnings  
3 derived from investing balances of the agricultural permanent fund, the  
4 normal school permanent fund, the permanent common school fund, the  
5 scientific permanent fund, and the state university permanent fund  
6 shall be allocated to their respective beneficiary accounts. All  
7 earnings to be distributed under this subsection (4)(a) shall first be  
8 reduced by the allocation to the state treasurer's service fund  
9 pursuant to RCW 43.08.190.

10 (b) The following accounts and funds shall receive eighty percent  
11 of their proportionate share of earnings based upon each account's or  
12 fund's average daily balance for the period: The aeronautics account,  
13 the aircraft search and rescue account, the county arterial  
14 preservation account, the department of licensing services account, the  
15 essential rail assistance account, the ferry bond retirement fund, the  
16 grade crossing protective fund, the high capacity transportation  
17 account, the highway bond retirement fund, the highway safety account,  
18 the marine operating fund, the motor vehicle fund, the motorcycle  
19 safety education account, the pilotage account, the public  
20 transportation systems account, the Puget Sound capital construction  
21 account, the Puget Sound ferry operations account, the recreational  
22 vehicle account, the rural arterial trust account, the safety and  
23 education account, the special category C account, the state patrol  
24 highway account, the transportation equipment fund, the transportation  
25 fund, the transportation improvement account, the transportation  
26 improvement board bond retirement account, and the urban arterial trust  
27 account.

28 (5) In conformance with Article II, section 37 of the state  
29 Constitution, no treasury accounts or funds shall be allocated earnings  
30 without the specific affirmative directive of this section.

31 **Sec. 38.** RCW 43.84.092 and 1999 c 380 s 8, 1999 c 309 s 928, 1999  
32 c 268 s 4, 1999 c 94 s 3, and 1999 c 94 s 2 are each reenacted and  
33 amended to read as follows:

34 (1) All earnings of investments of surplus balances in the state  
35 treasury shall be deposited to the treasury income account, which  
36 account is hereby established in the state treasury.

37 (2) The treasury income account shall be utilized to pay or receive  
38 funds associated with federal programs as required by the federal cash

1 management improvement act of 1990. The treasury income account is  
2 subject in all respects to chapter 43.88 RCW, but no appropriation is  
3 required for refunds or allocations of interest earnings required by  
4 the cash management improvement act. Refunds of interest to the  
5 federal treasury required under the cash management improvement act  
6 fall under RCW 43.88.180 and shall not require appropriation. The  
7 office of financial management shall determine the amounts due to or  
8 from the federal government pursuant to the cash management improvement  
9 act. The office of financial management may direct transfers of funds  
10 between accounts as deemed necessary to implement the provisions of the  
11 cash management improvement act, and this subsection. Refunds or  
12 allocations shall occur prior to the distributions of earnings set  
13 forth in subsection (4) of this section.

14 (3) Except for the provisions of RCW 43.84.160, the treasury income  
15 account may be utilized for the payment of purchased banking services  
16 on behalf of treasury funds including, but not limited to, depository,  
17 safekeeping, and disbursement functions for the state treasury and  
18 affected state agencies. The treasury income account is subject in all  
19 respects to chapter 43.88 RCW, but no appropriation is required for  
20 payments to financial institutions. Payments shall occur prior to  
21 distribution of earnings set forth in subsection (4) of this section.

22 (4) Monthly, the state treasurer shall distribute the earnings  
23 credited to the treasury income account. The state treasurer shall  
24 credit the general fund with all the earnings credited to the treasury  
25 income account except:

26 (a) The following accounts and funds shall receive their  
27 proportionate share of earnings based upon each account's and fund's  
28 average daily balance for the period: The capitol building  
29 construction account, the Cedar River channel construction and  
30 operation account, the Central Washington University capital projects  
31 account, the charitable, educational, penal and reformatory  
32 institutions account, the common school construction fund, the county  
33 criminal justice assistance account, the county sales and use tax  
34 equalization account, the data processing building construction  
35 account, the deferred compensation administrative account, the deferred  
36 compensation principal account, the department of retirement systems  
37 expense account, the drinking water assistance account, the Eastern  
38 Washington University capital projects account, the education  
39 construction fund, the emergency reserve fund, the federal forest

1 revolving account, the health services account, the public health  
2 services account, the health system capacity account, the personal  
3 health services account, the state higher education construction  
4 account, the higher education construction account, the highway  
5 infrastructure account, the industrial insurance premium refund  
6 account, the judges' retirement account, the judicial retirement  
7 administrative account, the judicial retirement principal account, the  
8 local leasehold excise tax account, the local real estate excise tax  
9 account, the local sales and use tax account, the medical aid account,  
10 the mobile home park relocation fund, the municipal criminal justice  
11 assistance account, the municipal sales and use tax equalization  
12 account, the natural resources deposit account, the perpetual  
13 surveillance and maintenance account, the public employees' retirement  
14 system plan 1 account, the public employees' retirement system plan 2  
15 account, the Puyallup tribal settlement account, the resource  
16 management cost account, the site closure account, the special wildlife  
17 account, the state employees' insurance account, the state employees'  
18 insurance reserve account, the state investment board expense account,  
19 the state investment board commingled trust fund accounts, the  
20 supplemental pension account, the teachers' retirement system plan 1  
21 account, the teachers' retirement system plan 2 account, the tobacco  
22 prevention and control account, the tobacco settlement account, the  
23 transportation infrastructure account, the tuition recovery trust fund,  
24 the University of Washington bond retirement fund, the University of  
25 Washington building account, the volunteer fire fighters' and reserve  
26 officers' relief and pension principal ((account)) fund, the volunteer  
27 fire fighters' ((relief and pension)) and reserve officers'  
28 administrative ((account)) fund, the Washington judicial retirement  
29 system account, the Washington law enforcement officers' and fire  
30 fighters' system plan 1 retirement account, the Washington law  
31 enforcement officers' and fire fighters' system plan 2 retirement  
32 account, the Washington state health insurance pool account, the  
33 Washington state patrol retirement account, the Washington State  
34 University building account, the Washington State University bond  
35 retirement fund, the water pollution control revolving fund, and the  
36 Western Washington University capital projects account. Earnings  
37 derived from investing balances of the agricultural permanent fund, the  
38 normal school permanent fund, the permanent common school fund, the  
39 scientific permanent fund, and the state university permanent fund

1 shall be allocated to their respective beneficiary accounts. All  
2 earnings to be distributed under this subsection (4)(a) shall first be  
3 reduced by the allocation to the state treasurer's service fund  
4 pursuant to RCW 43.08.190.

5 (b) The following accounts and funds shall receive eighty percent  
6 of their proportionate share of earnings based upon each account's or  
7 fund's average daily balance for the period: The aeronautics account,  
8 the aircraft search and rescue account, the county arterial  
9 preservation account, the department of licensing services account, the  
10 essential rail assistance account, the ferry bond retirement fund, the  
11 grade crossing protective fund, the high capacity transportation  
12 account, the highway bond retirement fund, the highway safety account,  
13 the motor vehicle fund, the motorcycle safety education account, the  
14 pilotage account, the public transportation systems account, the Puget  
15 Sound capital construction account, the Puget Sound ferry operations  
16 account, the recreational vehicle account, the rural arterial trust  
17 account, the safety and education account, the special category C  
18 account, the state patrol highway account, the transportation equipment  
19 fund, the transportation fund, the transportation improvement account,  
20 the transportation improvement board bond retirement account, and the  
21 urban arterial trust account.

22 (5) In conformance with Article II, section 37 of the state  
23 Constitution, no treasury accounts or funds shall be allocated earnings  
24 without the specific affirmative directive of this section.

25 **Sec. 39.** RCW 43.84.092 and 1999 c 380 s 9, 1999 c 309 s 929, 1999  
26 c 268 s 5, and 1999 c 94 s 4 are each reenacted and amended to read as  
27 follows:

28 (1) All earnings of investments of surplus balances in the state  
29 treasury shall be deposited to the treasury income account, which  
30 account is hereby established in the state treasury.

31 (2) The treasury income account shall be utilized to pay or receive  
32 funds associated with federal programs as required by the federal cash  
33 management improvement act of 1990. The treasury income account is  
34 subject in all respects to chapter 43.88 RCW, but no appropriation is  
35 required for refunds or allocations of interest earnings required by  
36 the cash management improvement act. Refunds of interest to the  
37 federal treasury required under the cash management improvement act  
38 fall under RCW 43.88.180 and shall not require appropriation. The

1 office of financial management shall determine the amounts due to or  
2 from the federal government pursuant to the cash management improvement  
3 act. The office of financial management may direct transfers of funds  
4 between accounts as deemed necessary to implement the provisions of the  
5 cash management improvement act, and this subsection. Refunds or  
6 allocations shall occur prior to the distributions of earnings set  
7 forth in subsection (4) of this section.

8 (3) Except for the provisions of RCW 43.84.160, the treasury income  
9 account may be utilized for the payment of purchased banking services  
10 on behalf of treasury funds including, but not limited to, depository,  
11 safekeeping, and disbursement functions for the state treasury and  
12 affected state agencies. The treasury income account is subject in all  
13 respects to chapter 43.88 RCW, but no appropriation is required for  
14 payments to financial institutions. Payments shall occur prior to  
15 distribution of earnings set forth in subsection (4) of this section.

16 (4) Monthly, the state treasurer shall distribute the earnings  
17 credited to the treasury income account. The state treasurer shall  
18 credit the general fund with all the earnings credited to the treasury  
19 income account except:

20 (a) The following accounts and funds shall receive their  
21 proportionate share of earnings based upon each account's and fund's  
22 average daily balance for the period: The capitol building  
23 construction account, the Cedar River channel construction and  
24 operation account, the Central Washington University capital projects  
25 account, the charitable, educational, penal and reformatory  
26 institutions account, the common school construction fund, the county  
27 criminal justice assistance account, the county sales and use tax  
28 equalization account, the data processing building construction  
29 account, the deferred compensation administrative account, the deferred  
30 compensation principal account, the department of retirement systems  
31 expense account, the drinking water assistance account, the Eastern  
32 Washington University capital projects account, the education  
33 construction fund, the emergency reserve fund, the federal forest  
34 revolving account, the health services account, the public health  
35 services account, the health system capacity account, the personal  
36 health services account, the state higher education construction  
37 account, the higher education construction account, the highway  
38 infrastructure account, the industrial insurance premium refund  
39 account, the judges' retirement account, the judicial retirement

1 administrative account, the judicial retirement principal account, the  
2 local leasehold excise tax account, the local real estate excise tax  
3 account, the local sales and use tax account, the medical aid account,  
4 the mobile home park relocation fund, the municipal criminal justice  
5 assistance account, the municipal sales and use tax equalization  
6 account, the natural resources deposit account, the perpetual  
7 surveillance and maintenance account, the public employees' retirement  
8 system plan 1 account, the public employees' retirement system plan 2  
9 account, the Puyallup tribal settlement account, the resource  
10 management cost account, the site closure account, the special wildlife  
11 account, the state employees' insurance account, the state employees'  
12 insurance reserve account, the state investment board expense account,  
13 the state investment board commingled trust fund accounts, the  
14 supplemental pension account, the teachers' retirement system plan 1  
15 account, the teachers' retirement system combined plan 2 and plan 3  
16 account, the tobacco prevention and control account, the tobacco  
17 settlement account, the transportation infrastructure account, the  
18 tuition recovery trust fund, the University of Washington bond  
19 retirement fund, the University of Washington building account, the  
20 volunteer fire fighters' and reserve officers' relief and pension  
21 principal ((~~account~~)) fund, the volunteer fire fighters' ((~~relief and~~  
22 ~~pension~~)) and reserve officers' administrative ((~~account~~)) fund, the  
23 Washington judicial retirement system account, the Washington law  
24 enforcement officers' and fire fighters' system plan 1 retirement  
25 account, the Washington law enforcement officers' and fire fighters'  
26 system plan 2 retirement account, the Washington school employees'  
27 retirement system combined plan 2 and 3 account, the Washington state  
28 health insurance pool account, the Washington state patrol retirement  
29 account, the Washington State University building account, the  
30 Washington State University bond retirement fund, the water pollution  
31 control revolving fund, and the Western Washington University capital  
32 projects account. Earnings derived from investing balances of the  
33 agricultural permanent fund, the normal school permanent fund, the  
34 permanent common school fund, the scientific permanent fund, and the  
35 state university permanent fund shall be allocated to their respective  
36 beneficiary accounts. All earnings to be distributed under this  
37 subsection (4)(a) shall first be reduced by the allocation to the state  
38 treasurer's service fund pursuant to RCW 43.08.190.

1 (b) The following accounts and funds shall receive eighty percent  
2 of their proportionate share of earnings based upon each account's or  
3 fund's average daily balance for the period: The aeronautics account,  
4 the aircraft search and rescue account, the county arterial  
5 preservation account, the department of licensing services account, the  
6 essential rail assistance account, the ferry bond retirement fund, the  
7 grade crossing protective fund, the high capacity transportation  
8 account, the highway bond retirement fund, the highway safety account,  
9 the motor vehicle fund, the motorcycle safety education account, the  
10 pilotage account, the public transportation systems account, the Puget  
11 Sound capital construction account, the Puget Sound ferry operations  
12 account, the recreational vehicle account, the rural arterial trust  
13 account, the safety and education account, the special category C  
14 account, the state patrol highway account, the transportation equipment  
15 fund, the transportation fund, the transportation improvement account,  
16 the transportation improvement board bond retirement account, and the  
17 urban arterial trust account.

18 (5) In conformance with Article II, section 37 of the state  
19 Constitution, no treasury accounts or funds shall be allocated earnings  
20 without the specific affirmative directive of this section.

21 NEW SECTION. **Sec. 40.** A new section is added to chapter 48.01 RCW  
22 to read as follows:

23 (1) Except as required in RCW 48.21.045, 48.44.023, and 48.46.066,  
24 nothing in this title shall be construed to require a carrier, as  
25 defined in RCW 48.43.005, to offer any health benefit plan for sale.

26 (2) Nothing in this title shall prohibit a carrier as defined in  
27 RCW 48.43.005 from ceasing sale of any or all health benefit plans to  
28 new applicants if the closed plans are closed to all new applicants.

29 (3) This section is intended to clarify, and not modify, existing  
30 law.

31 NEW SECTION. **Sec. 41.** (1) The task force on health care  
32 reinsurance is created, and is composed of seven members, including:  
33 Three members appointed by the governor, one of whom shall be the chair  
34 of the Washington state health insurance pool; two members of the  
35 senate, one member of each party caucus appointed by the president of  
36 the senate; and two members of the house of representatives, one member  
37 of each party caucus appointed by the co-speakers of the house of

1 representatives. The chair shall be elected by the task force from  
2 among its members.

3 (2) The task force shall:

4 (a) Monitor the provisions of this act regarding its effect on:

5 (i) Carrier participation in the individual market, especially in  
6 areas where coverage is currently minimal or not available;

7 (ii) Affordability and availability of private health plan  
8 coverage;

9 (iii) Washington state health insurance pool operations;

10 (iv) The Washington basic health plan operations;

11 (v) The cost of the Washington state insurance pool;

12 (vi) Premium affordability in the individual and small group  
13 market;

14 (vii) The ability of consumers to purchase, renew, and change their  
15 health insurance coverage;

16 (viii) The availability of coverage for medical benefits such as,  
17 but not limited to, maternity and prescription drugs in the individual  
18 market; and

19 (ix) The number of uninsured people in the state of Washington;

20 (b) After studying the feasibility of reinsurance as a method of  
21 health insurance market stability, if appropriate, develop a  
22 reinsurance system implementation plan; and

23 (c) Seek participation from interested parties, including but not  
24 limited to consumer, carriers, health care providers, health care  
25 purchasers, and insurance brokers and agents, in an effective manner.

26 (3) In the conduct of its business, the task force shall have  
27 access to all health data available by statute to health-related state  
28 agencies and may, to the extent that funds are available, purchase  
29 necessary analytical and staff support.

30 (4) Task force members will receive no compensation for their  
31 service.

32 (5) The task force shall submit an interim report to the governor  
33 and the legislature in December 2000 and December 2001, and a final  
34 report no later than December 1, 2002.

35 (6) The task force expires December 31, 2002.

36 **Sec. 42.** RCW 70.47.010 and 1993 c 492 s 208 are each amended to  
37 read as follows:

1       (1)(a) The legislature finds that limitations on access to health  
2 care services for enrollees in the state, such as in rural and  
3 underserved areas, are particularly challenging for the basic health  
4 plan. Statutory restrictions have reduced the options available to the  
5 administrator to address the access needs of basic health plan  
6 enrollees. It is the intent of the legislature to authorize the  
7 administrator to develop alternative purchasing strategies to ensure  
8 access to basic health plan enrollees in all areas of the state,  
9 including: (i) The use of differential rating for managed health care  
10 systems based on geographic differences in costs; and (ii) limited use  
11 of self-insurance in areas where adequate access cannot be assured  
12 through other options.

13       (b) In developing alternative purchasing strategies to address  
14 health care access needs, the administrator shall consult with  
15 interested persons including health carriers, health care providers,  
16 and health facilities, and with other appropriate state agencies  
17 including the office of the insurance commissioner and the office of  
18 community and rural health. In pursuing such alternatives, the  
19 administrator shall continue to give priority to prepaid managed care  
20 as the preferred method of assuring access to basic health plan  
21 enrollees followed, in priority order, by preferred providers, fee for  
22 service, and self-funding.

23       (2) The legislature further finds that:

24       (a) A significant percentage of the population of this state does  
25 not have reasonably available insurance or other coverage of the costs  
26 of necessary basic health care services;

27       (b) This lack of basic health care coverage is detrimental to the  
28 health of the individuals lacking coverage and to the public welfare,  
29 and results in substantial expenditures for emergency and remedial  
30 health care, often at the expense of health care providers, health care  
31 facilities, and all purchasers of health care, including the state; and

32       (c) The use of managed health care systems has significant  
33 potential to reduce the growth of health care costs incurred by the  
34 people of this state generally, and by low-income pregnant women, and  
35 at-risk children and adolescents who need greater access to managed  
36 health care.

37       ~~((+2))~~ (3) The purpose of this chapter is to provide or make more  
38 readily available necessary basic health care services in an  
39 appropriate setting to working persons and others who lack coverage, at

1 a cost to these persons that does not create barriers to the  
2 utilization of necessary health care services. To that end, this  
3 chapter establishes a program to be made available to those residents  
4 not eligible for medicare who share in a portion of the cost or who pay  
5 the full cost of receiving basic health care services from a managed  
6 health care system.

7 ~~((+3))~~ (4) It is not the intent of this chapter to provide health  
8 care services for those persons who are presently covered through  
9 private employer-based health plans, nor to replace employer-based  
10 health plans. However, the legislature recognizes that cost-effective  
11 and affordable health plans may not always be available to small  
12 business employers. Further, it is the intent of the legislature to  
13 expand, wherever possible, the availability of private health care  
14 coverage and to discourage the decline of employer-based coverage.

15 ~~((+4))~~ (5)(a) It is the purpose of this chapter to acknowledge the  
16 initial success of this program that has (i) assisted thousands of  
17 families in their search for affordable health care; (ii) demonstrated  
18 that low-income, uninsured families are willing to pay for their own  
19 health care coverage to the extent of their ability to pay; and (iii)  
20 proved that local health care providers are willing to enter into a  
21 public-private partnership as a managed care system.

22 (b) As a consequence, the legislature intends to extend an option  
23 to enroll to certain citizens above two hundred percent of the federal  
24 poverty guidelines within the state who reside in communities where the  
25 plan is operational and who collectively or individually wish to  
26 exercise the opportunity to purchase health care coverage through the  
27 basic health plan if the purchase is done at no cost to the state. It  
28 is also the intent of the legislature to allow employers and other  
29 financial sponsors to financially assist such individuals to purchase  
30 health care through the program so long as such purchase does not  
31 result in a lower standard of coverage for employees.

32 (c) The legislature intends that, to the extent of available funds,  
33 the program be available throughout Washington state to subsidized and  
34 nonsubsidized enrollees. It is also the intent of the legislature to  
35 enroll subsidized enrollees first, to the maximum extent feasible.

36 (d) The legislature directs that the basic health plan  
37 administrator identify enrollees who are likely to be eligible for  
38 medical assistance and assist these individuals in applying for and  
39 receiving medical assistance. The administrator and the department of

1 social and health services shall implement a seamless system to  
2 coordinate eligibility determinations and benefit coverage for  
3 enrollees of the basic health plan and medical assistance recipients.

4 **Sec. 43.** RCW 70.47.020 and 1997 c 335 s 1 are each amended to read  
5 as follows:

6 As used in this chapter:

7 (1) "Washington basic health plan" or "plan" means the system of  
8 enrollment and payment (~~((on a prepaid capitated basis))~~) for basic  
9 health care services, administered by the plan administrator through  
10 participating managed health care systems, created by this chapter.

11 (2) "Administrator" means the Washington basic health plan  
12 administrator, who also holds the position of administrator of the  
13 Washington state health care authority.

14 (3) "Managed health care system" means: (a) Any health care  
15 organization, including health care providers, insurers, health care  
16 service contractors, health maintenance organizations, or any  
17 combination thereof, that provides directly or by contract basic health  
18 care services, as defined by the administrator and rendered by duly  
19 licensed providers, (~~((on a prepaid capitated basis))~~) to a defined  
20 patient population enrolled in the plan and in the managed health care  
21 system; or (b) a self-funded or self-insured method of providing  
22 insurance coverage to subsidized enrollees provided under RCW 41.05.140  
23 and subject to the limitations under RCW 70.47.100(7).

24 (4) "Subsidized enrollee" means an individual, or an individual  
25 plus the individual's spouse or dependent children: (a) Who is not  
26 eligible for medicare; (b) who is not confined or residing in a  
27 government-operated institution, unless he or she meets eligibility  
28 criteria adopted by the administrator; (c) who resides in an area of  
29 the state served by a managed health care system participating in the  
30 plan; (d) whose gross family income at the time of enrollment does not  
31 exceed (~~((twice))~~) two hundred percent of the federal poverty level as  
32 adjusted for family size and determined annually by the federal  
33 department of health and human services; and (e) who chooses to obtain  
34 basic health care coverage from a particular managed health care system  
35 in return for periodic payments to the plan. To the extent that state  
36 funds are specifically appropriated for this purpose, with a  
37 corresponding federal match, "subsidized enrollee" also means an  
38 individual, or an individual's spouse or dependent children, who meets

1 the requirements in (a) through (c) and (e) of this subsection and  
2 whose gross family income at the time of enrollment is more than two  
3 hundred percent, but less than two hundred fifty-one percent, of the  
4 federal poverty level as adjusted for family size and determined  
5 annually by the federal department of health and human services.

6 (5) "Nonsubsidized enrollee" means an individual, or an individual  
7 plus the individual's spouse or dependent children: (a) Who is not  
8 eligible for medicare; (b) who is not confined or residing in a  
9 government-operated institution, unless he or she meets eligibility  
10 criteria adopted by the administrator; (c) who resides in an area of  
11 the state served by a managed health care system participating in the  
12 plan; (d) who chooses to obtain basic health care coverage from a  
13 particular managed health care system; and (e) who pays or on whose  
14 behalf is paid the full costs for participation in the plan, without  
15 any subsidy from the plan.

16 (6) "Subsidy" means the difference between the amount of periodic  
17 payment the administrator makes to a managed health care system on  
18 behalf of a subsidized enrollee plus the administrative cost to the  
19 plan of providing the plan to that subsidized enrollee, and the amount  
20 determined to be the subsidized enrollee's responsibility under RCW  
21 70.47.060(2).

22 (7) "Premium" means a periodic payment, based upon gross family  
23 income which an individual, their employer or another financial sponsor  
24 makes to the plan as consideration for enrollment in the plan as a  
25 subsidized enrollee or a nonsubsidized enrollee.

26 (8) "Rate" means the (~~per capita~~) amount, negotiated by the  
27 administrator with and paid to a participating managed health care  
28 system, that is based upon the enrollment of subsidized and  
29 nonsubsidized enrollees in the plan and in that system.

30 **Sec. 44.** RCW 41.05.140 and 1994 c 153 s 10 are each amended to  
31 read as follows:

32 (1) Except for property and casualty insurance, the authority may  
33 self-fund, self-insure, or enter into other methods of providing  
34 insurance coverage for insurance programs under its jurisdiction  
35 (~~except property and casualty insurance~~), including the basic health  
36 plan as provided in chapter 70.47 RCW. The authority shall contract  
37 for payment of claims or other administrative services for programs  
38 under its jurisdiction. If a program does not require the prepayment

1 of reserves, the authority shall establish such reserves within a  
2 reasonable period of time for the payment of claims as are normally  
3 required for that type of insurance under an insured program. The  
4 authority shall endeavor to reimburse basic health plan health care  
5 providers under this section at rates similar to the average  
6 reimbursement rates offered by the state-wide benchmark plan determined  
7 through the request for proposal process.

8 (2) Reserves established by the authority for employee and retiree  
9 benefit programs shall be held in a separate trust fund by the state  
10 treasurer and shall be known as the public employees' and retirees'  
11 insurance reserve fund. The state investment board shall act as the  
12 investor for the funds and, except as provided in RCW 43.33A.160, one  
13 hundred percent of all earnings from these investments shall accrue  
14 directly to the public employees' and retirees' insurance reserve fund.

15 (3) Any savings realized as a result of a program created for  
16 employees and retirees under this section shall not be used to increase  
17 benefits unless such use is authorized by statute.

18 (4) Reserves established by the authority to provide insurance  
19 coverage for the basic health plan under chapter 70.47 RCW shall be  
20 held in a separate trust account in the custody of the state treasurer  
21 and shall be known as the basic health plan self-insurance reserve  
22 account. The state investment board shall act as the investor for the  
23 funds and, except as provided in RCW 43.33A.160, one hundred percent of  
24 all earnings from these investments shall accrue directly to the basic  
25 health plan self-insurance reserve account.

26 (5) Any program created under this section shall be subject to the  
27 examination requirements of chapter 48.03 RCW as if the program were a  
28 domestic insurer. In conducting an examination, the commissioner shall  
29 determine the adequacy of the reserves established for the program.

30 ~~((+5))~~ (6) The authority shall keep full and adequate accounts and  
31 records of the assets, obligations, transactions, and affairs of any  
32 program created under this section.

33 ~~((+6))~~ (7) The authority shall file a quarterly statement of the  
34 financial condition, transactions, and affairs of any program created  
35 under this section in a form and manner prescribed by the insurance  
36 commissioner. The statement shall contain information as required by  
37 the commissioner for the type of insurance being offered under the  
38 program. A copy of the annual statement shall be filed with the

1 speaker of the house of representatives and the president of the  
2 senate.

3 **Sec. 45.** RCW 43.79A.040 and 1999 c 384 s 8 and 1999 c 182 s 2 are  
4 each reenacted and amended to read as follows:

5 (1) Money in the treasurer's trust fund may be deposited, invested,  
6 and reinvested by the state treasurer in accordance with RCW 43.84.080  
7 in the same manner and to the same extent as if the money were in the  
8 state treasury.

9 (2) All income received from investment of the treasurer's trust  
10 fund shall be set aside in an account in the treasury trust fund to be  
11 known as the investment income account.

12 (3) The investment income account may be utilized for the payment  
13 of purchased banking services on behalf of treasurer's trust funds  
14 including, but not limited to, depository, safekeeping, and  
15 disbursement functions for the state treasurer or affected state  
16 agencies. The investment income account is subject in all respects to  
17 chapter 43.88 RCW, but no appropriation is required for payments to  
18 financial institutions. Payments shall occur prior to distribution of  
19 earnings set forth in subsection (4) of this section.

20 (4)(a) Monthly, the state treasurer shall distribute the earnings  
21 credited to the investment income account to the state general fund  
22 except under (b) and (c) of this subsection.

23 (b) The following accounts and funds shall receive their  
24 proportionate share of earnings based upon each account's or fund's  
25 average daily balance for the period: The Washington advanced college  
26 tuition payment program account, the agricultural local fund, the  
27 American Indian scholarship endowment fund, the basic health plan self-  
28 insurance reserve account, the Washington international exchange  
29 scholarship endowment fund, the developmental disabilities endowment  
30 trust fund, the energy account, the fair fund, the game farm  
31 alternative account, the grain inspection revolving fund, the juvenile  
32 accountability incentive account, the rural rehabilitation account, the  
33 stadium and exhibition center account, the youth athletic facility  
34 grant account, the self-insurance revolving fund, the sulfur dioxide  
35 abatement account, and the children's trust fund. However, the  
36 earnings to be distributed shall first be reduced by the allocation to  
37 the state treasurer's service fund pursuant to RCW 43.08.190.

1 (c) The following accounts and funds shall receive eighty percent  
2 of their proportionate share of earnings based upon each account's or  
3 fund's average daily balance for the period: The advanced right of way  
4 revolving fund, the advanced environmental mitigation revolving  
5 account, the federal narcotics asset forfeitures account, the high  
6 occupancy vehicle account, the local rail service assistance account,  
7 and the miscellaneous transportation programs account.

8 (5) In conformance with Article II, section 37 of the state  
9 Constitution, no trust accounts or funds shall be allocated earnings  
10 without the specific affirmative directive of this section.

11 NEW SECTION. **Sec. 46.** A new section is added to chapter 41.05 RCW  
12 to read as follows:

13 (1) The administrator shall design and offer a plan of health care  
14 coverage as described in subsection (2) of this section, for any person  
15 eligible under subsection (3) of this section. The health care  
16 coverage shall be designed and offered only to the extent that state  
17 funds are specifically appropriated for this purpose.

18 (2) The plan of health care coverage shall have the following  
19 components:

20 (a) Services covered more limited in scope than those contained in  
21 RCW 48.41.110(3);

22 (b) Enrollee cost-sharing that may include but not be limited to  
23 point-of-service cost-sharing for covered services;

24 (c) Deductibles of three thousand dollars on a per person per  
25 calendar year basis, and four thousand dollars on a per family per  
26 calendar year basis. The deductible shall be applied to the first  
27 three thousand dollars, or four thousand dollars, of eligible expenses  
28 incurred by the covered person or family, respectively, except that the  
29 deductible shall not be applied to clinical preventive services as  
30 recommended by the United States public health service. Enrollee out-  
31 of-pocket expenses required to be paid under the plan for cost-sharing  
32 and deductibles shall not exceed five thousand dollars per person, or  
33 six thousand dollars per family;

34 (d) Payment methodologies for network providers may include but are  
35 not limited to resource-based relative value fee schedules, capitation  
36 payments, diagnostic related group fee schedules, and other similar  
37 strategies including risk-sharing arrangements; and

1 (e) Other appropriate care management and cost-containment measures  
2 determined appropriate by the administrator, including but not limited  
3 to care coordination, provider network limitations, preadmission  
4 certification, and utilization review.

5 (3) Any person is eligible for coverage in the plan who resides in  
6 a county of the state where no carrier, as defined in RCW 48.43.005, or  
7 insurer regulated under chapter 48.15 RCW offers to the public an  
8 individual health benefit plan as defined in RCW 48.43.005 other than  
9 a catastrophic health plan as defined in RCW 48.43.005 at the time of  
10 application to the administrator. Such eligibility may terminate  
11 pursuant to subsection (7) of this section.

12 (4) The administrator may not reject an individual for coverage  
13 based upon preexisting conditions of the individual or deny, exclude,  
14 or otherwise limit coverage for an individual's preexisting health  
15 conditions; except that it shall impose a nine-month benefit waiting  
16 period for preexisting conditions for which medical advice was given,  
17 or for which a health care provider recommended or provided treatment,  
18 or for which a prudent layperson would have sought advice or treatment,  
19 within six months before the effective date of coverage. The  
20 preexisting condition waiting period shall not apply to prenatal care  
21 services. Credit against the waiting period shall be provided pursuant  
22 to subsection (5) of this section.

23 (5) The administrator shall credit any preexisting condition  
24 waiting period in the plan for a person who was enrolled at any time  
25 during the sixty-three day period immediately preceding the date of  
26 application for the plan in a group health benefit plan or an  
27 individual health benefit plan other than a catastrophic health plan.  
28 The administrator must credit the period of coverage the person was  
29 continuously covered under the immediately preceding health plan toward  
30 the waiting period of the new health plan. For the purposes of this  
31 subsection, a preceding health plan includes an employer-provided self-  
32 funded health plan.

33 (6) The administrator shall set the rates to be charged plan  
34 enrollees.

35 (7) When a carrier, as defined in RCW 48.43.005, or an insurer  
36 regulated under chapter 48.15 RCW, begins to offer an individual health  
37 benefit plan as defined in RCW 48.43.005 in a county where no carrier  
38 or insurer had been offering an individual health benefit plan:

1 (a) If the health benefit plan offered is other than a catastrophic  
2 health plan as defined in RCW 48.43.005, any person enrolled in the  
3 plan under subsection (3) of this section in that county shall no  
4 longer be eligible;

5 (b) The administrator shall provide written notice to any person  
6 who is no longer eligible for coverage under the plan within thirty  
7 days of the administrator's determination that the person is no longer  
8 eligible. The notice shall: (i) Indicate that coverage under the plan  
9 will cease ninety days from the date that the notice is dated; (ii)  
10 describe any other coverage options available to the person; and (iii)  
11 describe the enrollment process for the available options.

12 NEW SECTION. **Sec. 47.** RCW 48.41.180 (Offer of coverage to  
13 eligible persons) and 1987 c 431 s 18 are each repealed.

14 NEW SECTION. **Sec. 48.** If any provision of this act or its  
15 application to any person or circumstance is held invalid, the  
16 remainder of the act or the application of the provision to other  
17 persons or circumstances is not affected.

18 NEW SECTION. **Sec. 49.** Sections 37 and 38 of this act expire  
19 September 1, 2000.

20 NEW SECTION. **Sec. 50.** (1) Section 38 of this act takes effect  
21 July 1, 2000.

22 (2) Section 39 of this act takes effect September 1, 2000.

23 (3) Section 26 of this act takes effect on the first day of the  
24 month following the expiration of a one hundred eighty-day period  
25 beginning on the effective date of section 25 of this act.

26 NEW SECTION. **Sec. 51.** Except for sections 26, 38, and 39 of this  
27 act, this act is necessary for the immediate preservation of the public  
28 peace, health, or safety, or support of the state government and its  
29 existing public institutions, and takes effect immediately.

--- END ---