H-3431.2

HOUSE BILL 2362

State of Washington 56th Legislature 2000 Regular Session

By Representatives Cody, Kastama, Edwards, Edmonds, Schual-Berke, Conway, Kagi, Rockefeller, Kenney, Tokuda, Murray, Wolfe, Fisher, Ogden, Morris, Ruderman, Stensen, Lovick, Veloria, Wood, Kessler, Regala, Reardon, Cooper, Scott and Santos

Read first time 01/11/2000. Referred to Committee on Health Care.

AN ACT Relating to access to individual and small group health insurance coverage; amending RCW 48.41.020, 48.41.030, 48.41.040, 48.41.060, 48.41.080, 48.41.090, 48.41.100, 48.41.110, 48.41.120, 48.41.130, 48.41.140, 48.41.200, 48.43.015, 48.43.025, 48.43.035, 48.20.028, 48.21.045, 48.44.022, 48.44.023, 48.46.064, 48.46.066, 48.44.020, 48.46.060, 70.47.010, 70.47.020, 70.47.100, 41.05.140, 48.44.130, 48.46.300, 48.21.047, 48.44.024, and 48.46.068; reenacting and amending RCW 48.43.005, 70.47.060, 43.79A.040, 43.84.092, 43.84.092, and 43.84.092; adding new sections to chapter 48.41 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; creating new sections; repealing RCW 48.41.180; providing effective dates; providing an expiration date; and declaring an emergency.

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

TABLE OF CONTENTS

I. WASHINGTON STATE HEALTH INSURANCE POOL

Sec. 101. RCW 48.41.020 and 1987 c 431 s 2 are each amended to read as follows:

It is the purpose and intent of the legislature to provide access to health insurance coverage to all residents of Washington who are denied ((~~adequate~~)) health insurance ((~~for any reason~~)). ((~~It is the intent of the legislature that adequate levels of health insurance coverage be made available to residents of Washington who are otherwise considered uninsurable or who are underinsured.~~)) It is the intent of the Washington state health insurance coverage access act to:

(1) Provide a mechanism to ((~~insure~~)) ensure the availability of comprehensive health insurance to persons unable to obtain such insurance coverage on either an individual or group basis directly under any health plan;

(2) Establish a mechanism to equitably distribute the excessive risk sometimes associated with the individual health insurance markets among all health purchasers;

(3) Enable health carriers to better protect against the cost of covering high risk individuals; and

(4) Create incentives for carriers to develop quality health plans in the individual markets, rather than focus on risk avoidance.

Sec. 102. RCW 48.41.030 and 1997 c 337 s 6 are each amended to read as follows:

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

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

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

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

(4) "Commissioner" means the insurance commissioner.

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

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

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

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

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

(10) "Health coverage" means any group or individual disability insurance policy, health care service contract, and health maintenance agreement, except those contracts entered into for the provision of health care services pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, civilian health and medical program for the uniform services (CHAMPUS), 10 U.S.C. 55, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

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

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

((~~(13)~~)) (14) "Member" means any commercial insurer ((~~which~~)) that provides disability insurance or group stop loss insurance as defined in RCW 48.21.015, any health care service contractor, and any health maintenance organization licensed under Title 48 RCW. "Member" shall also mean, as soon as authorized by federal law, employers and other entities, including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after May 18, 1987. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products or those products excluded from the definition of "health coverage" set forth in subsection ((~~(9)~~)) (10) of this section.

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

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

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

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

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

(19) "Small employer" or "small group" has the same meaning as in RCW 48.43.005.

Sec. 103. RCW 48.41.040 and 1989 c 121 s 2 are each amended to read as follows:

(1) There is ((~~hereby~~)) created a nonprofit entity to be known as the Washington state health insurance pool.

(2) The pool has two functions:

(a) To offer health insurance coverage to eligible persons as defined in RCW 48.41.100. The continued need for this function shall be reviewed by the legislature in 2003 as provided in section 116 of this act; and

(b) To administer a risk sharing program for subsidization and equitable distribution of individual market losses experienced by health carriers, as provided in this chapter.

(3) All members in this state on or after May 18, 1987, shall be members of the pool. When authorized by federal law, all self-insured employers shall also be members of the pool.

((~~(2) Pursuant to chapter 34.05 RCW the commissioner shall, within ninety days after May 18, 1987, give notice to all members of the time and place for the initial organizational meetings of the pool.~~))

(4) A board of directors shall be established, which shall be comprised of ((~~nine~~)) eleven voting members. The ((~~commissioner~~)) governor shall select ((~~three~~)) six members of the board ((~~who~~)). One

shall represent ((~~(a) the general public, (b)~~)) health care providers, ((~~and (c)~~)) one shall represent health insurance agents, two shall represent consumers, one shall represent private small employer health care purchasers, and one shall represent private large employer health care purchasers. ((~~The remaining~~)) Four members of the board shall be selected by election from among the members of the pool((~~. The elected members shall~~)), and, to the extent possible, shall include at least one representative of health care service contractors, one representative of health maintenance organizations, and one representative of commercial insurers which provides disability insurance. The governor shall select one additional member of the board who shall serve as chair. The chair must not be an employee or director of a member of the pool. When self-insured organizations become eligible for participation in the pool, the membership of the board shall be increased to ((~~eleven and at least one member of the board shall represent the self-insurers~~)) thirteen. One of the new members shall be appointed by the governor, and one, who shall represent the self-insurers, shall be selected by election from among the members of the pool. The insurance commissioner shall serve as an ex officio nonvoting member.

((~~(3)~~)) (5) Except for the chair, the original voting members of the board of directors shall be appointed for intervals of one to three years. Thereafter, except for the chair, all voting board members shall serve a term of three years. The chair shall serve at the pleasure of the governor. Board members shall receive no compensation, but shall be reimbursed for all travel expenses as provided in RCW 43.03.050 and 43.03.060.

((~~(4)~~)) (6) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing pursuant to chapter 34.05 RCW, approve the plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of ((~~pool~~)) losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the

board or any time thereafter fails to submit acceptable amendments to the plan, the commissioner shall, within ninety days after notice and hearing pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

NEW SECTION. **Sec. 104.** Thirty days from the effective date of this section, the existing board of directors of the Washington state health insurance pool shall be dissolved, and the appointment or election of new members of the board under RCW 48.41.040 shall be effective. For purposes of setting terms, the new members of the board shall be treated as original members.

A. INDIVIDUAL HEALTH INSURANCE COVERAGE OFFERED BY THE POOL

Sec. 105. RCW 48.41.060 and 1997 c 337 s 5 are each amended to read as follows:

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

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

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

~~(3)~~)) shall:

(a) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and

rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices consistent with Washington state small group plan rating requirements under RCW 48.44.023 and 48.46.066;

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

~~(5)~~)) (b) Issue policies of health coverage in accordance with the requirements of this chapter; and

((~~(6)~~)) (c) Establish procedures for the administration of the premium discounts provided under RCW 48.41.200.

(2) For purposes of administering the risk sharing program, the board shall:

(a) Establish the standard health plans, as provided in section 117 of this act; and

(b) Determine carrier losses eligible for subsidization and disburse loss recovery payments, as provided in section 118 of this act.

(3)(a) For purposes of both offering health insurance coverage and administering the risk sharing program, the board shall assess members of the pool as provided in this chapter, and make advance assessments as may be reasonable and necessary for organizational or interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year.

(b) If the board determines that assessments in any accounting year will exceed the threshold level established in section 120 of this act, the board shall petition the commissioner for approval of an assessment in excess of the threshold amount.

(4) In addition, the board may:

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

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

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

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

Sec. 106. RCW 48.41.080 and 1997 c 231 s 212 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

(b) Administering procedures to identify those eligible for premium discounts under RCW 48.41.200;

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

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

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

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

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

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

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

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

Sec. 107. RCW 48.41.090 and 1989 c 121 s 6 are each amended to read as follows:

(1) For health insurance coverage issued by the pool, following the close of each accounting year, the pool administrator shall determine the net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction((~~,~~)). The numerator of ((~~which~~)) the fraction equals that member's total: Number of resident insured

persons, including spouse and dependents under the member's health plans; plus the number of resident beneficiaries covered under group stop loss insurance as defined in RCW 48.21.015, minus; the number of insured persons covered under individual policies or contracts in the state during the preceding calendar year((~~, and~~)). The denominator of ((~~which~~)) the fraction equals the total number of resident insured persons including spouses and dependents insured under all health plans, and resident beneficiaries covered under group stop loss insurance as defined in RCW 48.21.015, minus the number of insured persons covered under individual policies or contracts in the state by pool members.

(b) Any deficit incurred by the pool shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members.

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

(4) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

Sec. 108. RCW 48.41.100 and 1995 c 34 s 5 are each amended to read as follows:

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

if they reside in a county of the state where no member offers to the public all of the standard health plans as provided in section 202 of this act.

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

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

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

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs.

(3) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan.

Sec. 109. RCW 48.41.110 and 1997 c 231 s 213 are each amended to read as follows:

(1) The pool ((~~is authorized to~~)) shall offer health plans, including one or more managed care plans of coverage as provided in this section and RCW 48.41.120, 48.41.130, 48.41.140, 48.41.200, and sections 112 and 114 of this act. ((~~Such plans~~))

(2) The managed care plans of coverage may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. Covered persons enrolled in the pool on January 1, ((~~1997~~)) 2000, may continue coverage under the pool plan in which they are enrolled on that date. However, the pool may incorporate managed care features into such existing plans.

((~~(2)~~)) (3) The administrator shall prepare a brochure outlining the benefits and exclusions of the pool policy in plain language. After approval by the board ((~~of directors~~)), such brochure shall be made reasonably available to participants or potential participants.

(4) The health insurance policy issued by the pool shall pay only ((~~usual, customary, and~~)) reasonable ((~~charges~~)) amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illnesses, injuries, and conditions which are not otherwise limited or excluded. Eligible expenses are the ((~~usual,~~

~~customary, and~~)) reasonable ((~~charges~~)) amounts for the health care services and items for which benefits are extended under the pool policy. Such benefits shall at minimum include, but not be limited to, the following services or related items:

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

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

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

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

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

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

(p) Hospice services;

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

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

((~~(3)~~)) (5) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

((~~(4)~~)) (6) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork providers under point of service plans. The pool benefit policy cost shares and limitations must be consistent with those that are generally included in health plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

((~~(5)~~)) (7) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it ((~~may~~)) shall impose a ((~~three-month~~)) six-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider

recommended or provided treatment, within ((~~three~~)) six months before the effective date of coverage. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be provided as required by RCW 48.43.015.

Sec. 110. RCW 48.41.120 and 1989 c 121 s 8 are each amended to read as follows:

(1) Subject to the limitation provided in subsection (3) of this section, a pool policy offered in accordance with ((~~this chapter~~)) RCW 48.41.110(4) shall impose a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

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

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

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

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

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

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

Sec. 111. RCW 48.41.130 and 1997 c 231 s 215 are each amended to read as follows:

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

NEW SECTION. **Sec. 112.** A new section is added to chapter 48.41 RCW to read as follows:

The board shall design and offer, on or before June 1, 2000, an additional plan of coverage. The plan shall be designed to offer a more affordable plan option for pool enrollees, and shall have the following components:

(1) Services covered more limited in scope than those contained in RCW 48.41.110(4);

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

(3) Deductibles of three thousand dollars on a per person per calendar year basis, and four thousand dollars on a per family per calendar year basis. The deductible shall be applied to the first three thousand dollars, or four thousand dollars, of eligible expenses incurred by the covered person or family, respectively, except that the deductible shall not be applied to clinical preventive services as recommended by the United States public health service;

(4) Alternative payment methodologies for network providers that may include but are not limited to resource-based relative value fee schedules, capitation payments, diagnostic related group fee schedules, and other similar strategies including risk sharing arrangements; and

(5) Other appropriate care management and cost containment measures determined appropriate by the board including but not limited to care coordination, provider network limitations, preadmission certification, and utilization review. Care management or cost containment measures

chosen by the board must be consistent with any applicable rules adopted by the commissioner under this title.

Sec. 113. RCW 48.41.140 and 1987 c 431 s 14 are each amended to read as follows:

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

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

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

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

NEW SECTION. **Sec. 114.** A new section is added to chapter 48.41 RCW to read as follows:

On or after July 1, 2001, the pool must offer to new applicants only the standard health plans established under section 117 of this act. All of the standard health plans must be offered.

Sec. 115. RCW 48.41.200 and 1997 c 231 s 214 are each amended to read as follows:

(1) The pool shall determine the standard risk rate by calculating the average group standard rate for groups comprised of up to fifty persons charged by the five largest members offering coverages in the state comparable to the pool coverage. In the event five members do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Maximum rates for pool coverage shall be one hundred fifty percent for the indemnity health plan and, for the managed care plan and the plan established under section 112 of this act, one hundred twenty-five percent ((~~for managed care plans~~)) of the rates established as applicable for group standard risks in groups comprised of up to fifty persons.

(2) Maximum rates for standard health plans issued by the pool under section 114 of this act shall, for each plan, be one hundred percent of the average rate charged for that plan by the five largest members offering the standard health plans in the state. In the event five members do not offer the standard health plans, the rates shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage.

(3) For any person fifty-five years old or older purchasing pool coverage other than a standard health plan:

(a) The rate shall be reduced by thirty percent from what it would otherwise be if their current gross family income is less than two hundred fifty-one percent of the federal poverty level;

(b) The rate shall be reduced by fifteen percent from what it would otherwise be if their current gross family income is more than two hundred fifty percent but less than three hundred one percent of the federal poverty level.

NEW SECTION. **Sec. 116.** A new section is added to chapter 48.41 RCW to read as follows:

(1) On or before October 15, 2002, the joint legislative audit and review committee shall submit recommendations to the health policy committees of the senate and the house of representatives regarding the continued need for the pool to offer health insurance coverage to individuals residing in Washington state.

(2) In developing its recommendations, the joint legislative audit and review committee shall consider:

(a) The extent to which comprehensive health plans are being offered to the public in each county of the state;

(b) The stability of the individual insurance market in each county of the state; and

(c) Any other information deemed relevant by the committee.

B. RISK SHARING PROGRAM

NEW SECTION. **Sec. 117.** A new section is added to chapter 48.41 RCW to read as follows:

(1) On or before November 1, 2000, the board shall establish the policy and contract forms and benefits levels for five standard health plans to be offered to individuals as provided in section 122 of this act.

(2) Proposed policy and contract forms and benefits levels for the five standard health plans shall be developed by a committee, chosen from and by the members of the pool who are carriers, and submitted to the board for review and approval. The board may modify the committee's proposal prior to approval.

(3) The standard health plans shall represent a range of health plans sufficiently diverse to meet the needs of individuals seeking health insurance coverage in Washington state. One standard health

plan shall be a basic health benefits plan, and four plans shall include enhanced benefits of proportionally increasing actuarial value.

(a) The basic health benefits plan shall be designed to meet the needs of healthy persons without chronic or serious illness.

(b) Appropriate options to obtain maternity care and prescription drug benefits must be available among the standard health plans. However, maternity care and prescription drug coverage need not be offered in all of the plans.

(c) At least one of the standard health plans shall offer benefits that are sufficiently comprehensive to meet the needs of persons with chronic illness.

(d) To ensure adequate choice of coverage options for individuals, each standard health plan shall offer varying levels of consumer cost-sharing, which may include deductibles, coinsurance, or point-of-service cost-sharing.

(4) In designing the standard health plans, the board also may:

(a) Include managed care and other cost containment measures. Care management or cost containment measures included in the plans must be consistent with any applicable rules adopted by the commissioner under this title; and

(b) Provide incentives for utilization of primary care and clinical preventive services recommended by the United States public health service.

NEW SECTION. **Sec. 118.** A new section is added to chapter 48.41 RCW to read as follows:

(1) Risk sharing shall be implemented through an assessment and loss subsidization mechanism. Every member shall be liable for an assessment to subsidize losses of members that result from issuing standard health plans to individuals, unless the member has received an exemption under subsection (2) of this section.

(2) A carrier may apply to the board, by a date established by the board, for an exemption from the assessment and subsidization of losses provided for in this section. A carrier that applies for an exemption shall agree to offer all of the standard health plans and to cover a minimum number of individuals. The formula for determining the minimum number of individuals a carrier must cover under this subsection shall be established by the board. If a carrier’s average monthly enrollment in any calendar year is less than the minimum determined by the board,

then the carrier shall be liable for an assessment for that year. In determining the amount of the assessment due from these carriers under section 119 of this act, the board shall deduct the number of insured individuals under the carrier's health plans from its total number of resident insured persons.

(3) The risk sharing program shall include parameters that will limit its costs. In determining the amount of a carrier's losses to be subsidized, the board shall consider at least the following:

(a) The proportion of a carrier's losses submitted for subsidization that are attributable to administration and claims management;

(b) The extent to which a carrier seeking subsidization of losses has implemented care management or care coordination practices for people with chronic illness covered by standard health plans issued by the carrier; and

(c) The relative health status of people covered by a carrier's standard health plans, in comparison to that of the general population.

NEW SECTION. **Sec. 119.** A new section is added to chapter 48.41 RCW to read as follows:

(1) For the risk sharing program, following the close of each accounting year, the board shall determine the amount of loss to be subsidized, on a per carrier and aggregate basis and the pool expenses of administration attributable to the risk sharing program.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner. The member's proportion of participation in the pool shall be determined by multiplying the total loss to be recovered by a fraction. The numerator of the fraction equals that member's total number of resident insured persons, including spouse and dependents under the member's health plans, plus the number of resident insured persons covered under stop loss policies issued to self-insured employer plans. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, insured under all health plans, including employer purchased stop loss policies.

(b) Any deficit incurred by the pool shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members.

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

(4) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, future losses includes reserves for incurred but not reported claims.

NEW SECTION. **Sec. 120.** A new section is added to chapter 48.41 RCW to read as follows:

In any accounting year, total pool assessments attributable to both offering health insurance coverage and the risk sharing program shall not exceed fifty cents per covered life per month. However, the board may petition the commissioner for approval of a greater specified amount. The commissioner shall approve such amount if he or she finds, after consideration of the (1) board's subsidy determination process; (2) number of subsidy-eligible lives; (3) size of the entire individual market; (4) morbidity experience of people who have purchased coverage through the pool and subsidy-eligible lives; and (5) morbidity experience of the entire individual market; that the amount petitioned by the board is not greater than is necessary to fulfill the purposes of this chapter. For the purpose of making this determination, the commissioner may, at the expense of the pool, seek independent actuarial certification of the need for the increase.

II. INSURANCE ACCESS RULES

Sec. 201. RCW 48.43.005 and 1997 c 231 s 202 and 1997 c 55 s 1 are each reenacted and amended to read as follows:

((~~Unless otherwise specifically provided,~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

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

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

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

((~~(5)~~)) (4) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

((~~(6)~~)) (5) "Community rate" means the average rate resulting from the pooling of medical experience of all enrollees in the group purchasing coverage in a specified market.

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

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

(8) "Creditable coverage" means coverage of an individual under any of the following:

(a) An employer-sponsored group health plan including self-funded plans;

(b) A health plan issued by a carrier, without regard to whether the coverage is offered in the group market, the individual market, or otherwise;

(c) Medicare, Title XVIII of the federal social security act;

(d) Medicaid, Title XIX of the federal social security act;

(e) Medical and dental care sponsored by the federal government for members and certain former members of the uniformed services, and for their dependents;

(f) A medical care program of the Indian health service or of a tribal organization;

(g) The Washington state health insurance pool under chapter 48.41 RCW;

(h) A health plan offered under the federal employees health benefits program, Title 5 U.S.C. chapter 89;

(i) The Washington basic health plan, as provided in chapter 70.47 RCW, and any state-funded medical program administered by the department of social and health services under chapter 74.09 RCW; and

(j) A health benefit plan under section 5(e) of the federal peace corps act (22 U.S.C. Sec. 2504(e)).

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

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

((~~(10)~~)) (11) "Eligible individual" means an individual who meets the following conditions:

(a) The individual has at least eighteen months of creditable coverage as of the date on which the individual seeks coverage;

(b) The individual's most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any of these plans;

(c) The individual is not eligible for coverage under any of the following: (i) An employer-sponsored group health plan; (ii) medicare, Title XVIII of the federal social security act; (iii) medicaid, Title XIX of the federal social security act;

(d) The individual does not have other health insurance coverage;

(e) The individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and

(f) If the individual has been offered the option of continuing coverage under the federal consolidated omnibus budget reconciliation act continuation provision, under 29 U.S.C. Sec. 1161, the individual has both elected and exhausted the continuation coverage.

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

((~~(11)~~)) (13) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(12)~~)) (14) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(13)~~)) (15) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

((~~(14)~~)) (16) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment

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

((~~(15)~~)) (17) "Health care provider" or "provider" means:

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

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

((~~(16)~~)) (18) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(17)~~)) (19) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

((~~(18)~~)) (20) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

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

((~~(19)~~)) (21) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

((~~(20)~~)) (22) "Open enrollment" means, for purposes of portability of individual health plan coverage, the ((~~annual sixty-two~~)) semiannual thirty-day periods during the months of January and July ((~~and August~~)) during which every health carrier offering individual health plan coverage must ((~~accept onto individual coverage any state resident within the carrier's service area regardless of health condition who submits an application in accordance with RCW 48.43.035(1)~~)) credit any preexisting condition exclusion or limitation satisfied under creditable coverage without a significant break in coverage toward the new health plan.

((~~(21)~~)) (23) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (24) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23)~~)) (25) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(24)~~)) (26) "Significant break in coverage" means a period of ninety consecutive days during all of which the individual does not have creditable coverage.

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

((~~(25)~~)) (28) "Standard health plan" means any of the health plans established under section 117 of this act.

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

((~~(26)~~)) (30) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 202.** A new section is added to chapter 48.43 RCW to read as follows:

(1) On or after July 1, 2001, a carrier shall, as a condition of issuing health plans in Washington state, offer all of the standard individual plans established under section 117 of this act. A carrier shall be deemed to have satisfied its obligation to provide the standard individual health plans by paying an assessment as provided in section 118 of this act.

(2) Individual health plans offered to new applicants on or after July 1, 2001, shall be limited to the standard health plans established under section 117 of this act.

Sec. 203. RCW 48.43.015 and 1995 c 265 s 5 are each amended to read as follows:

(1) Every health carrier shall waive any preexisting condition exclusion or limitation applicable to group health coverage, other than small group health coverage, for persons who have creditable coverage without a significant break in coverage as of their first day of coverage, or if there is a waiting period under an employer-sponsored group health plan, the first day of the waiting period. If the person has creditable coverage without a significant break in coverage for at least three months, the carrier may not impose preexisting condition exclusions or limitations. If the person has creditable coverage without a significant break in coverage for less than three months, the carrier must reduce the duration of the preexisting condition exclusion or limitation by the number of days of creditable coverage the individual has.

(2) Every health carrier shall waive any preexisting condition exclusion or limitation applicable to small group health coverage for persons who have creditable coverage without a significant break in coverage as of their first day of coverage, or if there is a waiting period under an employer-sponsored group health plan, the first day of the waiting period. If the person has creditable coverage without a significant break in coverage for at least six months, the carrier may not impose preexisting condition exclusions or limitations.

If the person has creditable coverage without a significant break in coverage for less than six months, the carrier must reduce the duration of the preexisting condition exclusion or limitation by the number of days of creditable coverage the individual has.

(3)(a) Every health carrier shall waive any preexisting condition exclusion or limitation ((~~for persons or groups who had similar health coverage under a different health plan at any time during the three-month period immediately preceding the date of application for the new health plan if such person was continuously covered under the immediately preceding health plan~~)) applicable to individual coverage for eligible individuals, as defined in RCW 48.43.005, seeking to purchase individual coverage.

(b) Every health carrier shall waive any preexisting condition exclusion or limitation applicable to individual coverage for persons who had creditable coverage without a significant break in coverage, when the individual's most recent coverage is equivalent to the health coverage the individual seeks to purchase; or provides significantly greater benefits than the health coverage the individual seeks to purchase. If the person ((~~was continuously covered~~)) has creditable coverage without a significant break in coverage for at least ((~~three~~)) six months ((~~under the immediately preceding health plan~~)), the carrier may not impose ((~~a waiting period for coverage of~~)) preexisting condition((~~s~~)) exclusions or limitations. If the person ((~~was continuously covered~~)) has creditable coverage without a significant break in coverage for less than ((~~three~~)) six months ((~~under the immediately preceding health plan~~)), the carrier must ((~~credit any waiting period under the immediately preceding health plan toward the new health plan. For the purposes of this subsection, a preceding health plan includes an employer provided self-funded health plan.~~

~~(2) Subject to the provisions of subsection (1) of this section, nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its existing health plans. In addition, nothing in this section requires a carrier to waive benefit limitations not related to an individual or group's preexisting conditions or health history.~~)) reduce the duration of the preexisting condition exclusion or limitation by the number of days of creditable coverage the individual has.

(c)(i) A health carrier may impose a preexisting condition exclusion or limitation of up to six months duration for individuals who have creditable coverage without a significant break in coverage when the benefits under the individual's most recent coverage are significantly less than the health coverage plan the individual seeks to purchase, if the application for the new health plan is submitted in

a month other than designated open enrollment periods. The preexisting exclusion or limitation imposed shall relate only to the benefits under the new health coverage plan that were not included in the individual's most recent prior creditable coverage.

(ii) Every health carrier shall waive any preexisting condition exclusion or limitation for individuals who have creditable coverage without a significant break in coverage when the benefits under the individual's most recent coverage are significantly less than the health coverage plan the individual seeks to purchase and the application is submitted during an open enrollment period. If the person has creditable coverage without a significant break in coverage for at least six months, the carrier may not impose preexisting condition exclusions or limitations. If the person has creditable coverage without a significant break in coverage for less than six months, the carrier must reduce the duration of the preexisting condition exclusion or limitation by the number of days of creditable coverage the individual has. The preexisting exclusion or limitation imposed shall relate only to the benefits under the new health coverage plan that were not included in the individual's most recent prior creditable coverage.

(iii) An individual whose application for a new health plan is submitted in a month other than a designated open enrollment period shall be considered to have applied during an open enrollment period if the individual is seeking individual coverage because he or she has lost coverage under a group health plan due to loss of employment, his or her employer has terminated his or her group health plan, or he or she has relocated to a new service area not served by their most recent health plan.

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

NEW SECTION. **Sec. 204.** A new section is added to chapter 48.43 RCW to read as follows:

(1) No carrier may reject an individual for individual health plan coverage, or a group for small group health plan coverage, based upon

preexisting conditions of the individual or members of the group and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions except as provided in this section.

(2) Preexisting condition exclusions or limitations imposed upon a person enrolling in individual or small group coverage shall be no more restrictive than six months for a preexisting condition for which medical advice was given or for which a health care provider recommended or provided treatment within six months prior to the effective date of coverage.

(3) For individual coverage, preexisting condition exclusions or limitations shall not apply to prenatal care services. For small group coverage, preexisting condition exclusions or limitations shall not apply to pregnancy.

(4) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals who are higher than average health risks.

Sec. 205. RCW 48.43.025 and 1995 c 265 s 6 are each amended to read as follows:

(1) For group health benefit plans other than small group health benefit plans, no carrier may reject ((~~an individual~~)) a group for health plan coverage based upon preexisting conditions of ((~~the individual~~)) a person in a group and no carrier may deny, exclude, or otherwise limit coverage for ((~~an individual's~~)) a person's preexisting health conditions((~~; except that~~)).

(2) Except as provided in RCW 48.43.015, a carrier may impose a three-month benefit ((~~waiting period~~)) exclusion or limitation for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage. Preexisting condition exclusions or limitations shall not apply to pregnancy.

((~~(2)~~)) (3) No carrier may avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. A new or changed rate

classification will be deemed an attempt to avoid the provisions of this section if the new or changed classification would substantially discourage applications for coverage from individuals or groups who are higher than average health risks. These provisions apply only to individuals who are Washington residents.

Sec. 206. RCW 48.43.035 and 1995 c 265 s 7 are each amended to read as follows:

(1) All health carriers shall accept for enrollment any state resident within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, genetic information, geographic location, employment status, socioeconomic status, conditions arising out of acts of domestic violence, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

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

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

(a) Nonpayment of premium;

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

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

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

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

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

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

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

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

(b) A carrier replaces a product and the replacement product is provided to all covered persons within that class or line of business, includes all of the services covered under the replaced product, and does not significantly limit access to the kind of services covered under the replaced product. The health plan may also allow unrestricted conversion to a fully comparable product. On or after July 1, 2001, a carrier may satisfy the requirement of this section by offering, as a replacement product for an individual product other than a standard health plan, the standard health plan that is most comparable, with respect to actuarial value and services covered, to the product being discontinued; or

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

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

III. ELIMINATION OF MODEL PLAN MANDATE IN INDIVIDUAL AND SMALL GROUP MARKET

Sec. 301. RCW 48.20.028 and 1997 c 231 s 207 are each amended to read as follows:

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 302. RCW 48.21.045 and 1995 c 265 s 14 are each amended to read as follows:

(1)((~~(a) An insurer offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual~~

~~enrolled in the basic health plan. Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. An insurer offering a health benefit plan that does not include benefits in the basic health plan shall clearly disclose these differences to the small employer in a brochure approved by the commissioner.~~

~~(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320 if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees.~~

~~(2) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, benefits in excess of the basic health plan services. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.~~

~~(3)~~)) Premium rates for health benefit plans for small employers as defined in this ((~~section~~)) chapter shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

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

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage.

((~~(4)~~)) (2) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state. Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (3)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (4) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

((~~(7)~~)) (5) As used in this section, "health benefit plan," "small employer," ((~~"basic health plan,"~~)) "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

Sec. 303. RCW 48.44.022 and 1997 c 231 s 208 are each amended to read as follows:

(1)(((~~(a) A health care service contractor offering any health benefit plan to any individual shall offer and actively market to all individuals a health benefit plan providing benefits identical to the schedule of covered health benefits that are required to be delivered to an individual enrolled in the basic health plan, subject to the provisions in RCW 48.43.025 and 48.43.035. Nothing in this subsection shall preclude a contractor from offering, or an individual from~~

~~purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A contractor offering a health benefit plan that does not include benefits provided in the basic health plan shall clearly disclose these differences to the individual in a brochure approved by the commissioner.~~

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

(c) The health care service contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 304. RCW 48.44.023 and 1995 c 265 s 16 are each amended to read as follows:

(1)(((~~(a) A health care services contractor offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may~~

~~have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A contractor offering a health benefit plan that does not include benefits in the basic health plan shall clearly disclose these differences to the small employer in a brochure approved by the commissioner.~~

~~(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees.~~

~~(2) Nothing in this section shall prohibit a health care service contractor from offering, or a purchaser from seeking, benefits in excess of the basic health plan services. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.~~

~~(3)~~)) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

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

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.

((~~(4)~~)) (2) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state. Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (3)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (4) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 305. RCW 48.46.064 and 1997 c 231 s 209 are each amended to read as follows:

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 306. RCW 48.46.066 and 1995 c 265 s 18 are each amended to read as follows:

(1)(((~~(a) A health maintenance organization offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan. Nothing in this subsection shall preclude a health maintenance organization from offering, or a small employer from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A health maintenance organization offering a health benefit plan that does not include benefits in the basic health plan shall clearly disclose these differences to the small employer in a brochure approved by the commissioner.~~

~~(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees.~~

~~(2) Nothing in this section shall prohibit a health maintenance organization from offering, or a purchaser from seeking, benefits in excess of the basic health plan services. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.~~

~~(3)~~)) Premium rates for health benefit plans for small employers as defined in ((~~this section~~)) RCW 48.43.005 shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

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

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage.

((~~(4)~~)) (2) The health benefit plans authorized by this section that are lower than the required offering shall not supplant or supersede any existing policy for the benefit of employees in this state. Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

((~~(5)~~)) (3)(a) Except as provided in this subsection, requirements used by a health maintenance organization in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A health maintenance organization shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A health maintenance organization may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

((~~(6)~~)) (4) A health maintenance organization must offer coverage to all eligible employees of a small employer and their dependents. A health maintenance organization may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A health maintenance organization may not modify a health plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

IV. INDIVIDUAL AND GROUP MARKET RATE SETTING

Sec. 401. RCW 48.44.020 and 1990 c 120 s 5 are each amended to read as follows:

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

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

(a) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which

unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; or

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

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

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

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

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

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

(h) If any contract for health care services with any state agency, division, subdivision, board, or commission or with any political subdivision, municipal corporation, or quasi-municipal corporation fails to comply with state law.

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

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

NEW SECTION. **Sec. 402.** A new section is added to chapter 48.44 RCW to read as follows:

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

(a) "Claims" means the cost to the health care service contractor of health care services, as defined in RCW 48.43.005, provided to a contract holder or paid to or on behalf of a contract holder in accordance with the terms of a health benefit plan, as defined in RCW

48.43.005. This includes capitation payments or other similar payments made to providers for the purpose of paying for health care services for an enrollee.

(b) "Claims reserved" means: (i) The liability for claims that have been reported but not paid; (ii) the liability for claims that have not been reported but which may reasonably be expected; and (iii) additional claims reserves for other accepted accounting purposes.

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

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

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

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

(b) These rates shall be calculated to include no more than twenty percent of premium attributable to all nonclaims expenses, including administrative costs, calculated over the length of the rating period. Rates shall be calculated for a period of one year.

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

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

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

(c) The aggregate percentage of premium attributable to (i) administrative expenses; and (ii) contributions to reserves or profit that were used in determining the community rate; and

(d) A certification by a member of the American academy of actuaries, or other person acceptable to the commissioner, that the adjusted community rate charged can be reasonably expected to result in

an aggregate loss ratio that meets or exceeds the loss ratio standard established in subsection (6) of this section.

(4) By the last day of May each year any health care service contractor providing individual or small group health benefit plans in this state shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual and small group health benefit plans offered in this state in aggregate for the preceding calendar year. The filing shall include a certification by a member of the American academy of actuaries, or other person acceptable to the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) If the commissioner has not contested the calculation prior to the expiration of sixty working days, commencing with the date the filing is delivered to the commissioner, the loss ratio as filed by the carrier shall be used in calculating refunds under subsection (5) of this section.

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

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

(5) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (6) of this section, refunds are due and the following shall apply:

(a) The health care service contractor shall calculate a percentage of premium to be refunded to contract holders by subtracting the actual loss ratio for the preceding year from the loss ratio standard established in subsection (6) of this section.

(b) The refund due to each individual or small group contract holder is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each contract holder in the previous calendar year. Interest shall be added to the refund due at a five percent annual rate calculated from the end of the calendar year for which refunds are due to the date the refunds are made.

(c) Any refund due a contract holder in excess of ten dollars shall be mailed to the contract holder at his or her last known mailing address or credited against any premiums due.

(d) All refunds equal to or less than ten dollars shall be aggregated and such amounts shall be remitted to the Washington state health insurance pool to be used as directed by the pool board of directors.

(e) Any refund required to be issued under this section shall be issued within thirty days after the actual loss ratio is determined under subsection (4) of this section.

(f) Any refund issued by a health care service contractor to a contract holder under this section that remains unclaimed by that contract holder one year from the date it was issued shall be remitted to the Washington state health insurance pool to be used as directed by the pool board of directors. Health care service contractors that comply with this subsection shall be relieved of liability for any unclaimed refunds.

(6) The loss ratio standard applicable to this section shall be eighty percent.

Sec. 403. RCW 48.46.060 and 1989 c 10 s 10 are each amended to read as follows:

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

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

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

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

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

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

(d) If the benefits provided therein ((~~are unreasonable in relation to the amount charged for the agreement~~)) contain unreasonable restrictions;

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

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

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

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

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

NEW SECTION. **Sec. 404.** A new section is added to chapter 48.46 RCW to read as follows:

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

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

(b) "Claims reserved" means: (i) The liability for claims that have been reported but not paid; (ii) the liability for claims that have not been reported but which may reasonably be expected; and (iii) additional claims reserves for other accepted accounting purposes.

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

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

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

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

(b) These rates shall be calculated to include no more than twenty percent of premium attributable to all nonclaims expenses, including administrative costs, calculated over the length of the rating period. Rates shall be calculated for a period of one year.

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

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

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

(c) The aggregate percentage of premium attributable to (i) administrative expenses; and (ii) contributions to reserves or profit that were used in determining the community rate; and

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

(4) By the last day of May each year any health maintenance organization providing individual or small group health benefit plans in this state shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual and small group health benefit plans offered in the state in aggregate for the preceding calendar year. The filing shall include a certification by a member of the American academy of actuaries, or other person acceptable to the commissioner, that the actual loss ratio has been calculated in accordance with accepted actuarial principles.

(a) If the commissioner has not contested the calculation prior to the expiration of sixty working days, commencing with the date the filing is delivered to the commissioner, the loss ratio as filed by the carrier shall be used in calculating refunds under subsection (5) of this section.

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

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

(5) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection (6) of this section, refunds are due and the following shall apply:

(a) The health maintenance organization shall calculate a percentage of premium to be refunded to enrollees and small group

agreement holders by subtracting the actual loss ratio for the preceding year from the loss ratio standard established in subsection (6) of this section.

(b) The refund due to each enrollee or small group agreement holder is the percentage calculated in (a) of this subsection, multiplied by the premium earned from each enrollee or small group agreement holder in the previous calendar year. Interest shall be added to the refund due at a five percent annual rate calculated from the end of the calendar year for which refunds are due to the date the refunds are made.

(c) Any refund due an enrollee or small group agreement holder in excess of ten dollars shall be mailed to the enrollee or small group agreement holder at his or her last known mailing address or credited against any premiums due.

(d) All refunds equal to or less than ten dollars shall be aggregated and such amounts shall be remitted to the Washington state health insurance pool to be used as directed by the pool board of directors.

(e) Any refund required to be issued under this section shall be issued within thirty days after the actual loss ratio is determined under subsection (4) of this section.

(f) Any refund issued by a health maintenance organization to an enrollee or small group agreement holder under this section that remains unclaimed by that enrollee or small group agreement holder one year from the date it was issued shall be remitted to the Washington state health insurance pool to be used as directed by the pool board of directors. Health maintenance organizations that comply with this subsection shall be relieved of liability for any unclaimed refunds.

(6) The loss ratio standard applicable to this section shall be eighty percent.

V. WASHINGTON BASIC HEALTH PLAN

Sec. 501. RCW 70.47.010 and 1993 c 492 s 208 are each amended to read as follows:

(1)(a) The legislature finds that limitations on access to health care services for enrollees in the state, such as in rural and underserved areas, are particularly challenging for the basic health plan. Statutory restrictions have reduced the options available to the

administrator to address the access needs of basic health plan enrollees. It is the intent of the legislature to authorize the administrator to develop alternative purchasing strategies to ensure access to basic health plan enrollees in all areas of the state, including: (i) The use of differential rating for managed health care systems based on geographic differences in costs; and (ii) limited use of self-insurance in areas where adequate access cannot be assured through other options.

(b) In developing alternative purchasing strategies to address health care access needs, the administrator shall consult with interested persons including health carriers, health care providers, and health facilities, and with other appropriate state agencies including the office of the insurance commissioner and the office of community and rural health. In pursuing such alternatives, the administrator shall continue to give priority to prepaid managed care as the preferred method of assuring access to basic health plan enrollees.

(2) The legislature further finds that:

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

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

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

((~~(2)~~)) (3) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents not eligible for medicare who share in a portion of the cost or who pay

the full cost of receiving basic health care services from a managed health care system.

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

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

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

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

(d) The legislature directs that the basic health plan administrator identify enrollees who are likely to be eligible for medical assistance and assist these individuals in applying for and receiving medical assistance. The administrator and the department of social and health services shall implement a seamless system to coordinate eligibility determinations and benefit coverage for enrollees of the basic health plan and medical assistance recipients.

Sec. 502. RCW 70.47.020 and 1997 c 335 s 1 are each amended to read as follows:

As used in this chapter:

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

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

(3) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, ((~~on a prepaid capitated basis~~)) to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(6).

(4) "Subsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who resides in an area of the state served by a managed health care system participating in the plan; (d) whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and (e) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan.

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator; (c) who resides in an area of the state served by a managed health care system participating in the plan; (d) who chooses to obtain basic health care coverage from a

particular managed health care system; and (e) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

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

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

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

Sec. 503. RCW 70.47.060 and 1998 c 314 s 17 and 1998 c 148 s 1 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services

through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.47.030, and such other factors as the administrator deems appropriate.

However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that the services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider.

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

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

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by

arrangement with the enrollee and through a mechanism acceptable to the administrator.

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

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

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

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

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

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical

assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

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

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

(10) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by

the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(11) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same or actuarially equivalent for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

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

commissioner and the department of health, to minimize duplication of effort.

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

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

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

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

Sec. 504. RCW 70.47.100 and 1987 1st ex.s. c 5 s 12 are each amended to read as follows:

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

(2) The plan shall allow, at least annually, an opportunity for enrollees to transfer their enrollments among participating managed health care systems serving their respective areas. The administrator

shall establish a period of at least twenty days in a given year when this opportunity is afforded enrollees, and in those areas served by more than one participating managed health care system the administrator shall endeavor to establish a uniform period for such opportunity. The plan shall allow enrollees to transfer their enrollment to another participating managed health care system at any time upon a showing of good cause for the transfer.

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

(3) Prior to negotiating with any managed health care system, the administrator shall determine, on an actuarially sound basis, the reasonable cost of providing the schedule of basic health care services, expressed in terms of upper and lower limits, and recognizing variations in the cost of providing the services through the various systems and in different areas of the state.

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

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

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

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

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

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

(6) The administrator may utilize a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 if: (a) It is necessary to provide access to covered basic health care services for subsidized enrollees; (b) funding for adequate reserves is available in the basic health plan self-insurance reserve account; and (c) other options for providing access to covered basic health care services for subsidized enrollees are not feasible.

Sec. 505. RCW 41.05.140 and 1994 c 153 s 10 are each amended to read as follows:

(1) Except for property and casualty insurance, the authority may self-fund, self-insure, or enter into other methods of providing insurance coverage for insurance programs under its jurisdiction ((~~except property and casualty insurance~~)), including the basic health plan as provided in chapter 70.47 RCW. The authority shall contract for payment of claims or other administrative services for programs under its jurisdiction. If a program does not require the prepayment of reserves, the authority shall establish such reserves within a reasonable period of time for the payment of claims as are normally required for that type of insurance under an insured program.

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

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

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

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

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

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

Sec. 506. RCW 43.79A.040 and 1999 c 384 s 8 and 1999 c 182 s 2 are each reenacted and amended to read as follows:

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

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

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

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

(b) The following accounts and funds shall receive their proportionate share of earnings based upon each account's or fund's average daily balance for the period: The Washington advanced college

tuition payment program account, the agricultural local fund, the American Indian scholarship endowment fund, the basic health plan self-insurance reserve account, the Washington international exchange scholarship endowment fund, the developmental disabilities endowment trust fund, the energy account, the fair fund, the game farm alternative account, the grain inspection revolving fund, the juvenile accountability incentive account, the rural rehabilitation account, the stadium and exhibition center account, the youth athletic facility grant account, the self-insurance revolving fund, the sulfur dioxide abatement account, and the children's trust fund. However, the earnings to be distributed shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

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

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

NEW SECTION. **Sec. 507.** A new section is added to chapter 48.41 RCW to read as follows:

The Washington state health insurance pool account is created in the custody of the state treasurer. All receipts from moneys specifically appropriated to the account must be deposited in the account. Expenditures from the account may be used only to cover deficits incurred by the Washington state health insurance pool under this chapter in excess of the threshold established in this section. To the extent funds are available in the account, funds shall be expended from the account only to offset that portion of the deficit that would otherwise have to be recovered by imposing an assessment on members in excess of a threshold of seventy cents per insured person per month. The commissioner shall authorize expenditures from the account, to the extent that funds are available in the account, upon certification by the pool board that assessments will exceed the threshold level established in this section. The account is subject to

the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

Sec. 508. RCW 43.84.092 and 1999 c 380 s 8, 1999 c 309 s 928, 1999 c 268 s 4, and 1999 c 94 s 2 are each reenacted and amended to read as follows:

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

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

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

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

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The capitol building

construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the drinking water assistance account, the Eastern Washington University capital projects account, the education construction fund, the emergency reserve fund, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the state higher education construction account, the higher education construction account, the highway infrastructure account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the medical aid account, the mobile home park relocation fund, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system plan 2 account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan 1 account, the teachers' retirement system plan 2 account, the tobacco prevention and control account, the tobacco settlement account, the transportation infrastructure account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the volunteer fire fighters' ((~~relief and pension principal account, the volunteer fire fighters' relief and pension administrative account~~)) and reserve officers' relief and pension principal fund, the volunteer fire fighters' and reserve

officers' administrative fund, the Washington judicial retirement system account, the Washington law enforcement officers' and fire fighters' system plan 1 retirement account, the Washington law enforcement officers' and fire fighters' system plan 2 retirement account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (4)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

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

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

Sec. 509. RCW 43.84.092 and 1999 c 380 s 8, 1999 c 309 s 928, 1999 c 268 s 4, 1999 c 94 s 3, and 1999 c 94 s 2 are each reenacted and amended to read as follows:

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

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

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

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

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory

institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the drinking water assistance account, the Eastern Washington University capital projects account, the education construction fund, the emergency reserve fund, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the state higher education construction account, the higher education construction account, the highway infrastructure account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the medical aid account, the mobile home park relocation fund, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system plan 2 account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan 1 account, the teachers' retirement system plan 2 account, the tobacco prevention and control account, the tobacco settlement account, the transportation infrastructure account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the volunteer fire fighters' ((~~relief and pension principal account, the volunteer fire fighters' relief and pension administrative account~~)) and reserve officers' relief and pension principal fund, the volunteer fire fighters' and reserve officers' administrative fund, the Washington judicial retirement system account, the Washington law enforcement officers' and fire fighters' system plan 1 retirement account, the Washington law

enforcement officers' and fire fighters' system plan 2 retirement account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (4)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

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

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

Sec. 510. RCW 43.84.092 and 1999 c 380 s 9, 1999 c 309 s 929, 1999 c 268 s 5, and 1999 c 94 s 4 are each reenacted and amended to read as follows:

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

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

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

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

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

account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the drinking water assistance account, the Eastern Washington University capital projects account, the education construction fund, the emergency reserve fund, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the state higher education construction account, the higher education construction account, the highway infrastructure account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the medical aid account, the mobile home park relocation fund, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system plan 2 account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan 1 account, the teachers' retirement system combined plan 2 and plan 3 account, the tobacco prevention and control account, the tobacco settlement account, the transportation infrastructure account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the volunteer fire fighters' ((~~relief and pension principal account, the volunteer fire fighters' relief and pension administrative account~~)) and reserve officers' relief and pension principal fund, the volunteer fire fighters' and reserve officers' administrative fund, the Washington judicial retirement system account, the Washington law enforcement officers' and fire fighters' system plan 1 retirement account, the Washington law enforcement officers' and fire fighters' system plan 2 retirement account, the Washington school employees' retirement system combined plan 2 and 3 account, the Washington state

health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (4)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

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

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

Sec. 511. RCW 48.44.130 and 1961 c 197 s 10 are each amended to read as follows:

No health care service contractor nor any individual acting on behalf thereof shall guarantee or agree to the payment of future dividends or future refunds of unused charges or savings in any specific or approximate amounts or percentages in respect to any contract being offered to the public, except in a group contract

containing an experience refund provision or in compliance with RCW 48.44.022.

Sec. 512. RCW 48.46.300 and 1983 c 106 s 8 are each amended to read as follows:

(1) No health maintenance organization nor any individual acting in behalf thereof may guarantee or agree to the payment of future dividends or future refunds of unused charges or savings in any specific or approximate amounts or percentages in respect to any contract being offered to the public, except in a group contract containing an experience refund provision or in compliance with RCW 48.46.064.

(2) The issuance, sale, or offer for sale in this state of securities of its own issue by any health maintenance organization domiciled in this state other than the memberships and bonds of a nonprofit corporation are subject to the provisions of chapter 48.06 RCW relating to obtaining solicitation permits.

Sec. 513. RCW 48.21.047 and 1995 c 265 s 22 are each amended to read as follows:

(1) No insurer shall offer any health benefit plan to any small employer without complying with the provisions of RCW 48.21.045((~~(5)~~)) (1).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care shall not be considered small employers and such plans shall not be subject to the provisions of RCW 48.21.045((~~(5)~~)) (1).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 514. RCW 48.44.024 and 1995 c 265 s 23 are each amended to read as follows:

(1) No health care service contractor shall offer any health benefit plan to any small employer without complying with the provisions of RCW 48.44.023((~~(5)~~)) (1).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care shall not be considered small employers and

such plans shall not be subject to the provisions of RCW 48.44.023((~~(5)~~)) (1).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 515. RCW 48.46.068 and 1995 c 265 s 24 are each amended to read as follows:

(1) No health maintenance organization shall offer any health benefit plan to any small employer without complying with the provisions of RCW 48.46.066((~~(5)~~)) (1).

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care shall not be considered small employers and such plans shall not be subject to the provisions of RCW 48.46.066((~~(5)~~)) (1).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

VI. MISCELLANEOUS

NEW SECTION. **Sec. 601.** RCW 48.41.180 (Offer of coverage to eligible persons) and 1987 c 431 s 18 are each repealed.

NEW SECTION. **Sec. 602.** Subheadings and the table of contents used in this act are not any part of the law.

NEW SECTION. **Sec. 603.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 604.** (1) Section 509 of this act takes effect July 1, 2000.

(2) Section 510 of this act takes effect September 1, 2000.

NEW SECTION. **Sec. 605.** Sections 508 and 509 of this act expire September 1, 2000.

NEW SECTION. **Sec. 606.** With the exception of sections 509 and 510 of this act, this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

--- END ---