2SSB 5930 - S AMD TO S AMD (S-2717.2/07)
By Senator Pflug

On page 13, line 30 of the amendment, after "19." strike all material through "section" on page 15, line 24 of the amendment and insert "The legislature finds that:

(1) The people of Washington have expressed strong concerns about health care costs and access to needed health services. Even if currently insured, they are not confident that they will continue to have health insurance coverage in the future and feel that they are getting less, but spending more.

(2) Many employers, especially small employers, struggle with the cost of providing employer-sponsored health insurance coverage to their employees, while others are unable to offer employer-sponsored health insurance due to its high cost. In addition, small employers continue to invest a significant amount of their time in the health insurance business as they are the lone gateway to group coverage for their employees. This is time better served meeting their customers' needs and fulfilling the many demands and challenges of our ever-changing marketplace. Even after much research has been done by the employer to secure a health benefit plan that works for everyone, it is, too often, that some individuals are forced into a choice of health care coverage they would have never made on their own, if given that chance.

(3) Six hundred thousand Washingtonians are uninsured. Three-quarters work or have a working family member; two-thirds are low income; and one-half are young adults. Many are low-wage workers who are not offered, or eligible for, employer-sponsored coverage. Others struggle with the burden of paying their share of the costs of employer-sponsored health insurance, while still others turn down their employer's offer of coverage due to its costs.

(4) Lack of portability remains a constant problem as thousands of Washington residents go uninsured every year simply because they are temporarily between jobs or their new job does not offer an affordable option for them. In addition, two-income earner families are punished by the system as they are forced to choose one employer's health

insurance plan over another without a chance to collect premium contributions from both.

(5) Access to health insurance and other health care spending has resulted in improved health for many Washingtonians. Yet, we are not receiving as much value as we should for each health care dollar spent in Washington state. By failing to sufficiently focus our efforts on prevention and management of chronic diseases, such as diabetes, asthma, and heart disease, too many Washingtonians suffer from complications of their illnesses. By failing to make health insurance coverage affordable for low-wage workers and self-employed people, health problems that could be treated in a doctor's office are treated in the emergency room or hospital. By failing to focus on the most effective ways to maintain our health and treat disease, Washingtonians have not made lifestyle changes proven to improve health, nor do they receive the most effective care.

(6) There are very few incentives for young adults, nineteen through thirty years old, to purchase their own health coverage. Young, healthy adults are often quoted rates that are incongruent with their level of risk and do not make financial sense when they look at the cost benefit ratio. By failing to offer the right incentives for this population to enroll in a health insurance plan, we have created layers of problems such as increased uncompensated care and less preventative care being sought.

NEW SECTION. **Sec. 20.** The legislature intends, through the public/private partnership reflected in this act, to improve our current health care system so that:

(1) Health insurance coverage is more affordable for employers, employees, self-employed people, and other individuals;

(2) The process of choosing and purchasing health insurance coverage is well-informed, clearer, and simpler;

(3) Prevention, chronic care management, wellness, and improved quality of care are a fundamental part of our health care system;

(4) Administrative costs at every level are reduced;

(5) As a result of these changes, more people in Washington state have access to affordable health insurance coverage and health outcomes in Washington state are improved; and

(6) More insurance coverage choices are available to all health consumers.

NEW SECTION. **Sec. 21.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Basic health plan" means the program administered under chapter 70.47 RCW.

(2) "Carrier" means a carrier as defined in RCW 48.43.005.

(3) "Commissioner" means the insurance commissioner established under RCW 48.02.010.

(4) "Eligible individual" means an individual who is eligible to participate in the exchange by reason of meeting one or more of the following qualifications:

(a) The individual is a Washington resident, meaning that the individual is, and continues to be, residing on a permanent and full-time basis in a place of permanent habitation in Washington that remains the person's principal residence and from which the person is absent only for temporary or transitory purposes. A person who is a full-time student attending an institution outside of Washington may maintain his or her Washington residency;

(b) The individual is not a Washington resident but is employed, at least twenty hours a week on a regular basis, at a Washington location by a bona fide employer, and the individual's employer does not offer a group health insurance plan, or the individual is not eligible to participate in any group health insurance plan offered by the individual's employer;

(c) The individual, whether a resident or not, is enrolled in, or eligible to enroll in, a participating employer plan;

(d) The individual is self-employed in Washington, and if a nonresident self-employed individual, the individual's principal place of business is in Washington;

(e) The individual is a full-time student attending an institution of higher education located in Washington;

(f) The individual, whether a resident or not, is a dependent of another individual who is an eligible individual;

(g) The individual is eligible for benefits under section 210 of the federal trade act of 2002, at 26 U.S.C. Sec. 35(c).

(5) "Eligible employer" means any individual, partnership, association, corporation, business trust, or person or group of persons employing one or more persons, and filing payroll tax information on each person.

(6) "Executive director" means an individual appointed by a vote of the exchange board to serve as the secretary of administration and finance for the exchange board.

(7) "Exchange" means the Washington state health insurance exchange established in section 203 of this act.

(8) "Exchange board" and "board" means the board of the Washington state health insurance exchange established in section 204 of this act.

(9) "Health plan" or "health benefit plan" means a health plan or health benefit plan as defined in RCW 48.43.005.

(10) "Participating individual" means a person who has been determined by the exchange to be, and continues to be, an eligible individual or an employee of a participating employer plan for purposes of obtaining coverage through the exchange.

(11) "Participating employer plan" means a group health plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186), that is sponsored by an employer and for which the plan sponsor has entered into an agreement with the exchange, in accordance with the provisions of section 207 of this act, for the exchange to offer and administer health insurance benefits for enrollees in the plan.

(12) "Preexisting condition" means a preexisting condition as defined in RCW 48.43.005.

(13) "Premium assistance payment" means a payment made to carriers by the exchange as provided in section 208 of this act.

Sec. 22. RCW 41.05.021 and 2006 c 103 s 2 are each amended to read as follows:

((~~(1)~~)) The Washington state health care authority is created within the executive branch. The authority shall have an administrator appointed by the governor, with the consent of the senate. The administrator shall serve at the pleasure of the governor. The administrator may employ up to seven staff members, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The administrator may delegate any power or duty vested in him or her by this chapter, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer state employees' insurance benefits and retired or disabled school employees' insurance benefits; administer the basic health plan pursuant to chapter 70.47 RCW; study state-

purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care; and implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services. The authority's duties include, but are not limited to, the following:

((~~(a)~~)) (1) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

((~~(b)~~)) (2) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

((~~(i)~~)) (a) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

((~~(ii)~~)) (b) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

((~~(iii)~~)) (c) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

((~~(iv)~~)) (d) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis;

((~~(v)~~)) (e) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031; and

((~~(vi)~~)) (f) In collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers:

((~~(A)~~)) (i) Use evidence-based medicine principles to develop common performance measures and implement financial incentives in contracts with insuring entities, health care facilities, and providers that:

((~~(I)~~)) (A) Reward improvements in health outcomes for individuals with chronic diseases, increased utilization of appropriate preventive health services, and reductions in medical errors; and

((~~(II)~~)) (B) Increase, through appropriate incentives to insuring entities, health care facilities, and providers, the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, and decreased medical errors;

((~~(B)~~)) (ii) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020(4), integrated delivery systems, and providers that:

((~~(I)~~)) (A) Facilitate diagnosis or treatment;

((~~(II)~~)) (B) Reduce unnecessary duplication of medical tests;

((~~(III)~~)) (C) Promote efficient electronic physician order entry;

((~~(IV)~~)) (D) Increase access to health information for consumers and their providers; and

((~~(V)~~)) (E) Improve health outcomes;

((~~(C)~~)) (iii) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005((~~.~~));

((~~(c)~~)) (3) To analyze areas of public and private health care interaction;

((~~(d)~~)) (4) To provide information and technical and administrative assistance to the board;

((~~(e)~~)) (5) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

((~~(f)~~)) (6) To establish billing procedures and collect funds from school districts in a way that minimizes the administrative burden on districts;

((~~(g)~~)) (7) To publish and distribute to nonparticipating school districts and educational service districts by October 1st of each year a description of health care benefit plans available through the authority and the estimated cost if school districts and educational service district employees were enrolled;

((~~(h)~~)) (8) To facilitate and cooperate with the Washington state health insurance exchange established in section 203 of this act as follows:

(a) Establish, if the exchange board finds it necessary, a risk adjustment mechanism for premiums paid to carriers;

(b) Establish and manage a system for determining eligibility for premium assistance payments and remitting premium assistance payments to the carriers in accordance with the health insurance exchange;

(9) To apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and make arrangements as to the use of these receipts to implement initiatives and strategies developed under this section; and

((~~(i)~~)) (10) To promulgate and adopt rules consistent with this chapter as described in RCW 41.05.160.

((~~(2) On and after January 1, 1996, the public employees' benefits board may implement strategies to promote managed competition among employee health benefit plans. Strategies may include but are not limited to:~~

~~(a) Standardizing the benefit package;~~

~~(b) Soliciting competitive bids for the benefit package;~~

~~(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;~~

~~(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.~~))

NEW SECTION. **Sec. 23.** (1) There is hereby established by the state of Washington the Washington state health insurance exchange as a body corporate and an independent instrumentality of the state of

Washington, created to serve public purposes provided for in this act, but with legal existence separate from that of the state of Washington.

(2) The exchange is hereby recognized as a not-for-profit corporation in accordance with the provisions of Title 24 RCW, and shall seek recognition of the same status by the United States in accordance with the provisions of the United States internal revenue code, 26 U.S.C. Sec. 501(c).

(3) The limited purpose of the exchange is to facilitate the availability, portability, choice, and adoption of private health insurance plans to eligible individuals and groups, as provided in this chapter.

(4) The exchange shall be administered by the executive director and governed by the Washington state health insurance exchange board established in section 204 of this act.

(5) The board shall appoint an executive director to serve as the secretary of administration and finance for the exchange and shall grant him or her the following powers and duties:

(a) Plan, direct, coordinate, and execute administrative functions in conformity with the policies and directives of the board;

(b) Employ professional and clerical staff as necessary;

(c) Report to the board on all operations under his or her control and supervision;

(d) Prepare an annual budget and manage the administrative expenses of the exchange; and

(e) Undertake any other activities necessary to implement the powers and duties set forth in this chapter.

NEW SECTION. **Sec. 24.** (1) The Washington state health insurance exchange board is hereby established. The function of the board is to develop and approve rules necessary for operation of the Washington state health insurance exchange.

(2) The exchange board shall be composed of thirteen voting members initially appointed by the governor as follows:

(a) A health economist;

(b) One representative of small businesses;

(c) One employee health plan benefits specialist;

(d) One representative of health care consumers;

(e) A physician licensed in good standing under chapter 18.57 RCW;

(f) A health insurance broker licensed in good standing under chapter 48.17 RCW;

(g) A representative of organized labor;

(h) A representative of business associations;

(i) A representative from the association of Washington health care plans;

(j) The assistant secretary of the department of social and health services, health recovery services administration, ex officio;

(k) The insurance commissioner, ex officio;

(l) The administrator of the health care authority, ex officio; and

(m) The executive director, ex officio.

(3) The governor shall appoint the initial members of the board to staggered terms not to exceed four years. Members appointed or elected thereafter shall serve two-year terms. Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. The executive director shall serve as chair of the board. Meetings of the board shall be at the call of the chair.

(4) The board may establish technical advisory committees or seek the advice of technical experts when necessary to execute the powers and duties included in section 205 of this act.

(5) Upon the end of each corresponding term of service for such positions as are to be prescribed, the board shall provide rules and guidelines, such as they are necessary, for the nomination and selection of industry representatives by their peers for the following seven board positions:

(a) One representative of small businesses;

(b) One employee health plan specialist;

(c) One representative of health care consumers;

(d) A physician licensed in good standing under chapter 18.57 RCW;

(e) A health insurance broker licensed in good standing under chapter 48.17 RCW;

(f) A representative of organized labor; and

(g) A representative of trade associations.

NEW SECTION. **Sec. 25.** The exchange board has the following duties and powers:

(1) Establish procedures for the enrollment of eligible individuals and groups, including:

(a) Publicizing the existence of the exchange and disseminating information on eligibility requirements and enrollment procedures for the exchange;

(b) Establishing procedures to determine each applicant's eligibility for purchasing insurance offered by the exchange, including a standard application form for eligible individuals and groups seeking to purchase health insurance through the exchange, as well as persons seeking a premium assistance payment. The application shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history, and payment method;

(c) Establishing rules related to minimum participation of employees in groups seeking to purchase health insurance through the exchange;

(d) Preparing and distributing certificate of eligibility forms and application forms to insurance brokers and the general public; and

(e) Establishing and administering procedures for the election of coverage by participating individuals during open enrollment periods and outside of open enrollment periods upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law. The procedures shall include preparing and distributing to participating individuals:

(i) Descriptions of the coverage, benefits, limitations, copayments, and premiums for all participating plans; and

(ii) Forms and instructions for electing coverage and arranging payment for coverage;

(2) Establish and manage a system of collecting and transmitting to the applicable carriers all premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to receive and process automatic payroll deductions for participating individuals enrolled in employer plans;

(3) Establish a plan for operating a health insurance service center to provide eligible individuals and employers with information on the exchange and manage exchange enrollment, and for publicizing the existence of the exchange and the exchange's eligibility requirements and enrollment procedures;

(4) Establish other procedures for operations of the exchange, including but not limited to procedures to:

(a) Seek and receive any grant funding from the federal government, departments or agencies of the state, and private foundations;

(b) Contract with professional service firms as may be necessary in the board's judgment, and to fix their compensation;

(c) Contract with companies which provide third-party administrative and billing services for insurance products;

(d) Charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter;

(e) Adopt bylaws for the regulation of its affairs and the conduct of its business;

(f) Sue and be sued in its own name, plead, and be impleaded;

(g) Establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered and appropriations from the state, and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the employee retirement income security act of 1974; and

(h) Enter into interdepartmental agreements with the office of the insurance commissioner, department of social and health services, health care authority, and any other state agencies the board deems necessary to implement this chapter; and

(5) Begin offering access to health benefit plans under this act on September 1, 2008.

NEW SECTION. **Sec. 26.** ENROLLMENT AND COVERAGE ELECTION. Any eligible individual may apply to participate in the exchange. An employer, a labor union, or an educational, professional, civic, trade, church, or social organization that has eligible individuals as employees or members may apply on behalf of those eligible persons. Upon determination by the exchange that an individual is eligible to participate in the exchange, he or she may enroll in a health plan offered through the exchange during the next open enrollment period or, outside of open enrollment periods, upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law. The initial open enrollment period is September 1, 2008, through November 30, 2008.

NEW SECTION. **Sec. 27.** PARTICIPATING EMPLOYER PLANS. (1) Any employer may apply to the exchange to be the sponsor of a participating employer plan.

(2) Any employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange that includes the following conditions:

(a) The sponsoring employer designates the exchange to be the plan's administrator for the employer's group health plan, and the exchange agrees to undertake the obligations required of a plan administrator under federal law;

(b) Any individual eligible to participate in the exchange by reason of his or her eligibility for coverage under the employer's participating employer plan, regardless of whether any such individual would otherwise qualify as an eligible individual if not enrolled in the participating employer plan, may elect coverage under any health plan offered through the exchange, and neither the employer nor the exchange shall limit such individual's choice of coverage from among all the health plans offered;

(c) The employer agrees that, for the term of the agreement, the employer will not offer to individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer's participating employer plan any separate or competing health plan, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan;

(d) The employer reserves the right to offer benefits supplemental to the benefits offered through the exchange, but any supplemental benefits offered by the employer shall constitute a separate plan or plans under federal law, for which the executive director shall not be the plan administrator and for which neither the executive director nor the exchange shall be responsible in any manner;

(e) The employer reserves the right to determine the criteria for eligibility and enrollment in the participating employer plan and the terms and amounts of the employer's contributions to that plan, so long as for the term of the agreement with the exchange the employer agrees not to alter or amend any criteria or contribution amounts at any time other than during an annual period designated by the exchange for

participating employer plans to make such changes in conjunction with the exchange's annual open enrollment period;

(f) The employer agrees to make available to the exchange any of the employer's documents, records, or information, including copies of the employer's federal and state tax and wage reports, that the executive director reasonably determines are necessary for the exchange to verify:

(i) That the employer is in compliance with the terms of its agreement with the exchange governing the employer's sponsorship of a participating employer plan;

(ii) That the participating employer plan is in compliance with applicable laws relating to employee welfare benefit plans, particularly those relating to nondiscrimination in coverage; and

(iii) The eligibility, under the terms of the employer's plan, of those individuals enrolled in the participating employer plan;

(g) The employer agrees to also sponsor a "cafeteria plan" as permitted under federal law, 26 U.S.C. Sec. 125, for all employees eligible for coverage under the employer's participating employer plan.

(3) Beginning on January 1, 2009, the state of Washington shall enter into an agreement with the exchange to be the sponsor of a participating employer plan on behalf of all individuals eligible for health insurance benefits paid in whole or in part by the state of Washington by reason of current or past employment by the state, or by reason of being a dependent of such an individual, except for any individuals who are eligible only for benefits consisting solely of coverage of expected benefits.

NEW SECTION. **Sec. 28.** EXCHANGE PREMIUM ASSISTANCE PROGRAM. (1) The exchange shall provide the basic and underlying administrative functions for the premium assistance program established in this section and remit premium assistance payments to carriers offering health plans through the exchange. All eligibility, regulatory, and programmatic decisions shall be made by the health care authority, and such information shall be shared with the exchange board as deemed necessary.

(2) Beginning January 1, 2009, the administrator of the health care authority shall accept applications for premium assistance from eligible individuals and employees of participating employer plans who have family income up to two hundred percent of the federal poverty

level, as determined annually by the federal department of health and human services, on behalf of themselves, their spouses, and their dependent children.

(3) The health care authority shall design and implement a schedule of premium assistance payments that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The benchmark plan for purposes of designing the premium assistance payment schedule shall be in conformity with the average quality of benefits covered in the top three subscribed plans in the individual insurance market as of January 1, 2007. After January 1, 2009, the benchmark plan for purposes of the premium assistance payment schedule shall be adjusted in conformity with the top three subscribed plans in the exchange.

The premium assistance schedule shall be applied to eligible individuals, and to the employee premium obligation remaining after employer premium contributions for employees of participating employer plans, so that employees benefit financially from their employers' contribution to the cost of their coverage through the exchange. Any surcharge included in the premium under section 211 of this act shall be included when determining the appropriate level of premium assistance payments.

(4) A financial sponsor may, with the prior approval of the executive director, pay the premium or any other amount on behalf of an eligible individual or employee of a participating employer plan, by arrangement with the individual or employee and through a mechanism acceptable to the executive director. The executive director shall establish a mechanism for receiving premium payments from the United States internal revenue service for eligible individuals who are eligible for benefits under section 210 of the federal trade act of 2002, at 26 U.S.C. Sec. 35(c).

(5) The exchange shall remit the premium assistance in an amount determined under subsection (3) of this section to the carrier offering the health plan in which the eligible individual or employee of a participating employer plan has chosen to enroll. If, however, such individual or employee has chosen to enroll in a high deductible health plan, any difference between the amount of premium assistance that the individual or employee would receive and the applicable premium rate for the high deductible health plan shall be deposited into a health savings account for the benefit of that individual or employee.

(6) As of January 1, 2009, all basic health plan enrollees under chapter 70.47 RCW shall transition to the premium assistance program. The health care authority shall provide information and assistance necessary to allow enrollees to successfully transition to the premium assistance program, including assistance with enrolling in the exchange and choosing a health plan during the 2008 open enrollment period.

NEW SECTION. **Sec. 29.** EXCHANGE PREMIUM ASSISTANCE ACCOUNT. The exchange premium assistance account is hereby established in the custody of the state treasurer. Any nongeneral fund--state funds collected for the exchange premium assistance program shall be deposited in the exchange premium assistance account. Moneys in the account shall be used exclusively for the purposes of administering the exchange premium assistance account, including payments to carriers on behalf of eligible individuals and employees of participating employer plans. Only the executive director may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 30.** BROKER COMMISSIONS. (1) When an eligible individual or eligible group is enrolled in the exchange by a health insurance broker or solicitor licensed under chapter 48.17 RCW, the exchange shall pay the broker a commission determined by the exchange board. In setting the commission, the exchange board shall consider rates of commissions paid to brokers for health plans issued under chapters 48.21, 48.44, and 48.46 RCW as of January 1, 2007.

(2) In cases where a membership organization enrolls in the exchange its eligible members, or the eligible members of its member entities, the plan chosen by each individual shall pay the organization a fee equal to the commission specified in subsection (1) of this section. Nothing in this section shall be deemed either to require a membership organization that enrolls persons in the exchange to be licensed by Washington as an insurance broker, or to permit such an organization to provide any other services requiring licensure as an insurance broker without first obtaining such license.

NEW SECTION. **Sec. 31.** SURCHARGE FOR EXCHANGE EXPENSES. (1) The exchange is authorized to apply a surcharge to all health benefit plans, which shall be used only to pay for administrative and

operational expenses of the exchange. Such a surcharge shall be applied uniformly to all health benefit plans offered through the exchange and shall be included in the premium for each health plan. As part of the premium, the surcharge shall be subject to the premium tax under RCW 48.14.020. These surcharges shall not be used to pay any premium assistance payments under this chapter.

(2) Each carrier participating in the exchange shall be required to furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his or her duties under this chapter.

NEW SECTION. **Sec. 32.** FINANCIAL REPORT. The exchange shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report as of the end of its fiscal year to its board, to the governor, and to the legislature, such reports to be in a form prescribed by the board. The board may investigate the affairs of the exchange, may severally examine the properties and records of the exchange, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the exchange. The exchange shall be subject to biennial audit by the state auditor.

NEW SECTION. **Sec. 33.** REPORTS. No later than two years after the exchange begins operation and every year thereafter, the exchange shall conduct a study of the exchange and the persons enrolled in the exchange and shall submit a written report to the governor and the legislature on the status and activities of the exchange based on data collected in the study. The report shall also be available to the general public. The study shall review:

(1) The operation and administration of the exchange, including surveys and reports of health benefit plans available to participating individuals and on the experience of the plans. The experience on the plans shall include data on enrollees in the exchange, the operation and administration of the exchange premium assistance program, expenses, claims statistics, complaints data, how the exchange met its goals, and other information deemed pertinent by the exchange; and

(2) Any significant observations regarding utilization and adoption of the exchange.

NEW SECTION. **Sec. 34.** REPORT ON MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM ENROLLEE PARTICIPATION IN THE EXCHANGE. On or before September 1, 2010, the Washington state institute for public policy in cooperation with the exchange board shall prepare a report and shall make recommendations regarding the participation of categorically needy medicaid and state children's health insurance program enrollees in the exchange. The report shall be submitted to the governor, the secretary of the department of social and health services, and relevant committees of the legislature. The report shall examine the following issues:

(1) The impact of medicaid and state children's health insurance program enrollees participating in the exchange, with respect to the utilization of services and cost of health plans offered through the exchange;

(2) Whether any distinction should be made between adult and child enrollees;

(3) Opportunities to provide plan design flexibility through medicaid state plan amendments;

(4) The need for a new section 1115 waiver from the federal government for moving a sizable portion of the medicaid and state children's health insurance program population into a defined contribution model;

(5) A study of other states that have attempted similar reforms involving a defined contribution model within their medicaid population and whether any ideas should be incorporated to facilitate the move of enrollees to the exchange;

(6) Whether any cost savings to the state would result from the incorporation of medicaid and state children's health insurance program enrollees to the exchange;

(7) The effect any such move would have on the premiums of current exchange enrollees;

(8) The capacity of participating carriers in the exchange to properly manage the care of medicaid and state children's health insurance program enrollees;

(9) The impact of expanded choice and cost sharing on medicaid enrollees;

(10) What specific categories of categorically needy medicaid and state children's health insurance program enrollees, if any, should be excluded from participation in the exchange; and

(11) If the board recommends participation of any medicaid eligible citizens in the exchange, how the composition of the board should be modified to reflect their participation.

NEW SECTION. **Sec. 35.** RULES. The executive director may adopt any rules necessary to implement this chapter.

Sec. 36. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

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

(2) "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)(e).

(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) "Catastrophic health plan" means:

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

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

(c) Any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient

services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

(6) "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.

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

(8) "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.

(9) "Creditable coverage" means continual coverage of the applicant under any of the following health plans, with no lapse in coverage of more than sixty-three days immediately prior to the date of application:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the social security act, approved July 30, 1965 (79 Stat. 291; 42 U.S.C. Sec. 1395c et seq. or 1395j et seq., respectively);

(d) Title XIX of the social security act, approved July 30, 1965 (79 Stat. 343; 42 U.S.C. Sec. 1396 et seq.), other than coverage consisting solely of benefits under section 1928;

(e) Chapter 55 of Title 10, United States Code (10 U.S.C. Sec. 1071 et seq.);

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

(g) A state health benefits risk pool;

(h) A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Sec. 8901 et seq.);

(i) The basic health plan as established in chapter 70.47 RCW;

(j) The health insurance pool as established in chapter 48.41 RCW;

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

(l) Any other qualifying coverage required by the health insurance portability and accountability act of 1996 (HIPAA, Title II), as it may be amended, or regulations under that act.

(10) "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.

((~~(10)~~)) (11) "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.

((~~(11)~~)) (12) "Eligible individual" means an individual, including a sole proprietor, who is a resident of Washington state. "Eligible individual" includes any individual who is eligible for benefits under section 210 of the federal trade act of 2002, at 26 U.S.C. Sec. 35(c).

(13) "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.

((~~(12)~~)) (14) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(13)~~)) (15) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(14)~~)) (16) "Exchange" means the Washington state health insurance exchange established in sections 203 through 205 of this act.

(17) "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.

((~~(15)~~)) (18) "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.

((~~(16)~~)) (19) "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.

((~~(17)~~)) (20) "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.

((~~(18)~~)) (21) "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.

((~~(19)~~)) (22) "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) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

((~~(20)~~)) (23) "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.

((~~(21)~~)) (24) "Participating individual" means a person who has been determined by the exchange to be, and continues to be, an eligible individual, an employee of a participating employer plan, or a member of an association health plan for purposes of obtaining coverage through the exchange. As used in this section, "association health plan" includes health plans offered through associations, trusts, and member-governed groups.

(25) "Participating employer plan" means a group health plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186), that is sponsored by an employer and for which the plan sponsor has entered

into an agreement with the exchange, in accordance with the provisions of section 207 of this act, for the exchange to offer and administer health insurance benefits for enrollees in the plan.

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

((~~(22)~~)) (27) "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)~~)) (28) "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)~~)) (29) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but 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. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or

sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

((~~(25)~~)) (30) "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)~~)) (31) "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. 37.** CERTIFICATION OF HEALTH BENEFIT PLANS BY THE OFFICE OF THE INSURANCE COMMISSIONER. (1) Health benefit plans offered through the exchange established in section 203 of this act shall be filed with the office of the insurance commissioner.

(2) No health benefit plan may be offered through the exchange unless the commissioner has first certified to the exchange that:

(a) The carrier seeking to offer the plan is an admitted carrier in Washington state and is in good standing with the office of the insurance commissioner;

(b) The plan meets the rating specifications under section 303 of this act, the preexisting condition provisions under RCW 48.43.015 and 48.43.025, the issue and renewal provisions of RCW 48.43.035, and the requirements of this section; and

(c) The plan and the carrier are in compliance with all other applicable Washington state laws.

(3) No plan shall be certified that excludes from coverage any individual otherwise determined by the exchange as meeting the eligibility requirements for participating individuals.

(4) Each certification shall be valid for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of either:

(a) Withdrawal by the commissioner; or

(b) Discontinuation of participation in the exchange by the carrier.

(5) Certification of a plan may be withdrawn only after notice to the carrier and opportunity for hearing. The commissioner may, however, decline to renew the certification of any carrier at the end of a certification term.

(6) Each plan certified by the commissioner as eligible to be offered through the exchange shall contain a detailed description of benefits offered including maximums, limitations, exclusions, and other benefit limits.

(7) The exchange shall not decline or refuse to offer, or otherwise restrict the offering to any participating individual, any plan that has obtained, in a timely fashion in advance of the annual open season, certification by the commissioner in accordance with the provisions of this section.

(8) The exchange shall not impose on any participating plan or any carrier or plan seeking to participate in the exchange any terms or conditions, including any requirements or agreements with respect to rates or benefits, beyond, or in addition to, those terms and conditions established and imposed by the commissioner in certifying plans under the provisions of this section.

(9) The commissioner shall establish and administer, rules and procedures for certifying plans to participate in the exchange, in accordance with the provisions of this section.

(10) Nothing in this section precludes an association or member-governed group from offering a commissioner-approved plan for purchase by its members in the exchange such that:

(a) Member-governed and association plans are not permitted to exclude other eligible exchange enrollees from obtaining coverage through the plan; and

(b) Member-governed groups and associations may provide a secondary level of membership for a nominal monthly fee that allows participation in said plan by nonmembers.

NEW SECTION. **Sec. 38.** HEALTH PLAN RATING METHODOLOGY. Premium rates for health benefit plans sold through the exchange are subject to the following provisions:

(1)(a) A carrier offering any health benefit plan through the exchange may offer and actively market a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection precludes a carrier from offering, or a consumer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A carrier offering a health benefit plan under this subsection shall clearly disclose all covered benefits to consumers in a brochure filed with the insurance commissioner.

(b) A health benefit plan offered under this subsection 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.

(2) Nothing in this section prohibits a carrier from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. 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) The carrier shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(a) Geographic area;

(b) Family size;

(c) Age; and

(d) Wellness activities.

(4) The adjustment for age in subsection (3)(c) of this section may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Participating

individuals under the age of twenty shall be treated as those age twenty.

(5) The carrier 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 are subject to the requirements of this section.

(6) 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.

(7) A discount for wellness activities is encouraged to reflect actuarially justified differences in utilization or cost attributed to such programs.

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

(9)(a) Except to the extent provided otherwise in (b) of this subsection, adjusted community rates established under this section shall pool the medical experience of all eligible individuals purchasing coverage through the exchange. However, annual rate adjustments for each health benefit plan offered through the exchange may vary by up to plus or minus six percentage points from the overall adjustment of a carrier's entire pool. In addition, high deductible health plans with health savings accounts are allowed a variance of plus four or minus eight percentage points from the overall adjustment of a carrier's entire pool. Any such overall adjustment is to be approved by the insurance commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all benefit plans will have a revenue neutral effect on the carrier's exchange clients. Variations of greater than six percentage points or minus eight percentage points for high deductible health plans with health savings accounts, are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(b) Carriers may treat persons under age thirty-five as a separate experience pool for purposes of establishing rates for health plans approved by the commissioner and available in the exchange. The rates charged for this age group are not subject to subsection (6) of this section.

Sec. 39. RCW 48.43.012 and 2001 c 196 s 6 are each amended to read as follows:

((~~(1)~~)) No carrier may reject an individual for ((~~an individual~~)) a health benefit plan through the exchange established in section 203 of this act based upon preexisting conditions of the individual except as provided in RCW 48.43.018.

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

~~(3) For an individual health benefit plan originally issued on or after March 23, 2000, preexisting condition waiting periods imposed upon a person enrolling in an individual health benefit plan shall be no more than nine months for a preexisting condition for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months prior to the effective date of the plan. No carrier may impose a preexisting condition waiting period on an individual health benefit plan issued to an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).~~

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

~~(5) 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. These provisions apply only to individuals who are Washington residents.~~))

Sec. 40. RCW 48.43.015 and 2004 c 192 s 5 are each amended to read as follows:

(1) For a health benefit plan offered to a group or through the exchange established in sections 203 through 205 of this act, every health carrier shall reduce any preexisting condition exclusion, limitation, or waiting period in the group health plan in accordance with the provisions of section 2701 of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg).

(2) For a health benefit plan offered to a group other than a small group:

(a) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for at least three months, then the carrier shall not impose a waiting period for coverage of preexisting conditions under the new health plan.

(b) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for less than three months, then the carrier shall credit the time covered under the immediately preceding health plan toward any preexisting condition waiting period under the new health plan.

(c) For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by chapter 192, Laws of 2004, and plans of the Washington state health insurance pool.

(3) For a health benefit plan offered ((~~to a small group~~)) through the exchange established in sections 203 through 205 of this act :

(a) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for at least nine months, then the carrier shall not impose a waiting period for coverage of preexisting conditions under the new health plan.

(b) If the individual applicant's immediately preceding health plan coverage terminated during the period beginning ninety days and ending sixty-four days before the date of application for the new plan and such coverage was similar and continuous for less than nine months, then the carrier shall credit the time covered under the immediately

preceding health plan toward any preexisting condition waiting period under the new health plan.

(c) For the purpose of this subsection, a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by chapter 192, Laws of 2004, and plans of the Washington state health insurance pool.

(4) ((~~For a health benefit plan offered to an individual, other than an individual to whom subsection (5) of this section applies, every health carrier shall credit any preexisting condition waiting period in that plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new health plan in a group health benefit plan or an individual health benefit plan, other than a catastrophic health plan, and (a) the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the health benefit plan the individual seeks to purchase; or (b) the person is seeking an individual health benefit plan due to his or her change of residence from one geographic area in Washington state to another geographic area in Washington state where his or her current health plan is not offered, if application for coverage is made within ninety days of relocation; or (c) the person is seeking an individual health benefit plan: (i) Because a health care provider with whom he or she has an established care relationship and from whom he or she has received treatment within the past twelve months is no longer part of the carrier's provider network under his or her existing Washington individual health benefit plan; and (ii) his or her health care provider is part of another carrier's provider network; and (iii) application for a health benefit plan under that carrier's provider network individual coverage is made within ninety days of his or her provider leaving the previous carrier's provider network. The carrier must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection (4), a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by chapter 192, Laws of 2004, and plans of the Washington state health insurance pool.~~

~~(5) Every health carrier shall waive any preexisting condition waiting period in its individual plans for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b)).~~

~~(6)~~)) Subject to the provisions of subsections (1) through ((~~(5)~~)) (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.

Sec. 41. RCW 48.43.018 and 2004 c 244 s 3 are each amended to read as follows:

(1) Except as provided in (a) through (e) of this subsection, ((~~a health carrier may~~)) the exchange established in section 203 of this act shall require any person applying ((~~for~~)) as an individual, outside of a plan permitted under federal law, 26 U.S.C. Sec. 125, for a health benefit plan, to complete the standard health questionnaire designated under chapter 48.41 RCW. The health questionnaire shall be kept by the exchange and shall be provided upon the request of any carrier receiving an application from an individual, separate from any employer plan, for coverage, and without such individual providing proof of creditable coverage lasting eighteen consecutive months or more.

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

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

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

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

(iii) Application for a health benefit plan under that carrier's provider network ((~~individual~~)) coverage is made within ninety days of his or her provider leaving the previous carrier's provider network; then completion of the standard health questionnaire shall not be a condition of coverage.

(c) If a person is seeking ((~~an individual~~)) a health benefit plan due to his or her having exhausted continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of exhaustion of continuation coverage. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such continuation coverage if application is made within ninety days prior to the date the continuation coverage would be exhausted and the effective date of the individual coverage applied for is the date the continuation coverage would be exhausted, or within ninety days thereafter.

(d) If a person is seeking ((~~an individual~~)) a health benefit plan due to his or her receiving notice that his or her coverage under a conversion contract is discontinued, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of discontinuation of eligibility under the conversion contract. A health carrier shall accept an application without a standard health questionnaire from a person currently covered by such conversion contract if application is made within ninety days prior to the date eligibility under the conversion contract would be discontinued and the effective date of the ((~~individual~~)) coverage applied for is the date eligibility under the conversion contract would be discontinued, or within ninety days thereafter.

(e) If a person is seeking ((~~an individual~~)) a health benefit plan and, but for the number of persons employed by his or her employer, would have qualified for continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if: (i) Application for coverage is made within ninety days of a qualifying event as defined in 29 U.S.C. Sec. 1163; and (ii) the person had at least twenty-four months of continuous group coverage immediately prior to the qualifying event. A health carrier shall accept an application without a standard health

questionnaire from a person with at least twenty-four months of continuous group coverage if application is made no more than ninety days prior to the date of a qualifying event and the effective date of the individual coverage applied for is the date of the qualifying event, or within ninety days thereafter.

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

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

(b) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the person's application for enrollment to both the person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, and shall include information about the Washington state health insurance pool and an application for such coverage. If the carrier does not provide or postmark such notice within fifteen business days, the application is deemed approved.

(3) If the person applying for ((~~an individual~~)) a health benefit plan: (a) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (b) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire and the carrier elects to accept the person for enrollment; or (c) is not required to complete the standard health questionnaire designated under this chapter under subsection (1)(a) or (b) of this section, the carrier shall accept the person for enrollment if he or she resides 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, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The 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.

Sec. 42. RCW 48.43.025 and 2001 c 196 s 9 are each amended to read as follows:

(1) For group health benefit plans for groups other than small groups, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that a carrier may impose a three-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 months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

(2) For group health benefit plans ((~~for small groups~~)) offered through the exchange established in sections 203 through 205 of this act, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions. Except that a carrier may impose a nine-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 six months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

(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. 43. RCW 48.43.035 and 2004 c 244 s 4 are each amended to read as follows:

For group health benefit plans and for health benefit plans offered through the exchange established in sections 203 through 205 of this act, the following shall apply:

(1) Except as provided in RCW 48.43.018, all health carriers shall accept for enrollment any state resident within the group to whom the plan is offered and 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, geographic location, employment status, socioeconomic status, 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. 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;

(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;

(c) No sooner than January 1, 2005, a carrier discontinues offering a particular type of health benefit plan offered for groups of up to two hundred if: (i) The carrier provides notice to each group of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll, with regard to small employer groups, in any other small employer group plan, or with regard to groups of up to two hundred, in any other applicable group plan, currently being offered by the carrier in the applicable group market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage;

(d) A carrier discontinues offering all health coverage in the small group market or for groups of up to two hundred, or both markets, in the state and discontinues coverage under all existing group health benefit plans in the applicable market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any group health coverage in this state in the applicable group market

involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

(e) 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.

(6) Notwithstanding any other provision of this section, the guarantee of continuity of coverage applies to a group of one only if: (a) The carrier continues to offer any other small employer group plan in which the group of one was eligible to enroll on the day prior to June 10, 2004; and (b) the person continues to qualify as a group of one under the criteria in place on the day prior to June 10, 2004.

NEW SECTION. **Sec. 44.** INSURANCE MARKET CONSOLIDATION. (1) A carrier shall not issue or renew an individual health benefit plan, other than through the exchange established in section 203 of this act, after January 1, 2009.

(2) A carrier shall not issue or renew a small group health benefit plan, including a plan offered through an association or member-governed group whether or not formed specifically for the purpose of purchasing health care, other than through the exchange established in section 203 of this act, after January 1, 2009.

NEW SECTION. **Sec. 45.** RULES. The commissioner may adopt any rules necessary to implement this chapter.

NEW SECTION. **Sec. 46.** STATEMENT OF COVERAGE FORM. (1) Each employer in Washington shall annually file with the commissioner a form for each employee employed within Washington indicating the health

insurance coverage status of the employee and the employee's dependents including the source of coverage and the name of the carrier or plan sponsor and, if no coverage is indicated:

(a) The employee's election to, in lieu of insurance coverage, take full personal responsibility for any and all health care-related expenses incurred while without coverage, including but not limited to: Preventative, emergency, and major medical services;

(b) The employee's forfeiture of any and all rights to any consideration or compensation in lieu of their employers financial contribution for health care;

(c) The employee's election to apply, or not apply, for coverage through the exchange; and

(d) The employee's election to be considered, or not to be considered, for any publicly financed health insurance program or premium subsidy program administered by Washington.

(2) Each form shall be signed by the individual to whom it pertains.

(3) Each self-employed individual in Washington shall annually file the same form with the commissioner.

(4) The secretary of the department of social and health services shall annually file the same form with the commissioner on behalf of all individuals receiving medical assistance benefits through a state-funded program, excepting such individuals as who are also covered by Part A or Part B of Title XVIII of the social security act (79 Stat. 291; 42 U.S.C. Sec. 1395c et seq. or 1395j et seq., respectively).

(5) For purposes of this section, "health insurance coverage" does not include any coverage consisting solely of one or more excepted benefits.

(6) The commissioner shall prepare and distribute such forms.

NEW SECTION. **Sec. 47.** HIGH-RISK TRANSFER POOL TASK FORCE. (1) The insurance market of Washington state can benefit from a more effective model for transferring high-risk claims among health insurance carriers.

(a) Carriers already pay for half of all high-risk claims through assessments that go toward the health insurance pool;

(b) Consumers are asked to share in that responsibility with higher premium costs; and

(c) Because they are the most directly affected by any high-risk transfer system, carriers are best suited to develop and come to agreement with the commissioner on a model that would effectively balance risk among carriers but not artificially shift costs to average-risk consumers or the state.

(2) On a date no later than September 1, 2007, the insurance commissioner shall convene a high-risk transfer pool task force consisting of representatives from each insurance carrier licensed to sell health benefit plans in Washington state as of January 1, 2007.

(3) A series of meetings shall be held among all task force members at a location to be determined by the commissioner. The following parameters apply:

(a) Discussion shall be limited to risk transfer solutions that minimize or exclude any state subsidy and preserve the affordability of insurance products for all state residents; and

(b) Such discussion shall examine the potential for leveraging additional federal funds for lower-income pool participants.

(4) In direct consultation with the commissioner, the task force members shall develop a risk transfer proposal that will best serve the exchange, its carriers, and its enrollees for transferring high-risk claims evenly among carriers.

(5) The task force shall consider active and proposed models from other states that function to spread high risk in the most equitable manner possible.

(6) The task force shall complete its work on a date no later than January 1, 2008, and shall publish a final report for public consumption.

(7) The final report shall be submitted to the house of representatives and senate health care committees for expedient consideration and further action.

NEW SECTION. **Sec. 48.** Part headings and captions used in this act are not any part of the law.

NEW SECTION. **Sec. 49.** The following acts or parts of acts are each repealed, effective January 1, 2009:

(1) RCW 48.01.260 (Health benefit plans--Carriers--Clarification) and 2000 c 79 s 40;

(2) RCW 48.20.025 (Schedule of rates for individual health benefit plans--Loss ratio--Remittance of premiums--Definitions) and 2003 c 248 s 8, 2001 c 196 s 1, & 2000 c 79 s 3;

(3) RCW 48.20.028 (Calculation of premiums--Adjusted community rating method--Definitions) and 2006 c 100 s 1, 2000 c 79 s 4, 1997 c 231 s 207, & 1995 c 265 s 13;

(4) RCW 48.20.029 (Calculation of premiums--Members of a purchasing pool--Adjusted community rating method--Definitions) and 2006 c 100 s 2;

(5) RCW 48.21.045 (Health plan benefits for small employers--Coverage--Exemption from statutory requirements--Premium rates--Requirements for providing coverage for small employers--Definitions) and 2004 c 244 s 1, 1995 c 265 s 14, & 1990 c 187 s 2;

(6) RCW 48.43.038 (Individual health plans --Guarantee of continuity of coverage --Exceptions) and 2000 c 79 s 25:

(7) RCW 48.43.041 (Individual health benefit plans--Mandatory benefits) and 2000 c 79 s 26;

(8) RCW 48.44.017 (Schedule of rates for individual contracts--Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 11 & 2000 c 79 s 29;

(9) RCW 48.44.021 (Calculation of premiums--Members of a purchasing pool--Adjusted community rating method--Definitions) and 2006 c 100 s 4;

(10) RCW 48.44.022 (Calculation of premiums--Adjusted community rate--Definitions) and 2006 c 100 s 3, 2004 c 244 s 6, 2000 c 79 s 30, 1997 c 231 s 208, & 1995 c 265 s 15;

(11) RCW 48.46.062 (Schedule of rates for individual agreements--Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 12 & 2000 c 79 s 32;

(12) RCW 48.46.063 (Calculation of premiums--Members of a purchasing pool--Adjusted community rating method--Definitions) and 2006 c 100 s 6;

(13) RCW 48.46.064 (Calculation of premiums--Adjusted community rate--Definitions) and 2006 c 100 s 5, 2004 c 244 s 8, 2000 c 79 s 33, 1997 c 231 s 209, & 1995 c 265 s 17;

(14) RCW 48.46.066 (Health plan benefits for small employers--Coverage--Exemption from statutory requirements--Premium rates--Requirements for providing coverage for small employers) and 2004 c 244 s 9, 1995 c 265 s 18, & 1990 c 187 s 4;

(15) RCW 70.47A.010 (Finding--Intent) and 2006 c 255 s 1;

(16) RCW 70.47A.020 (Definitions) and 2006 c 255 s 2;

(17) RCW 70.47A.030 (Program established--Administrator duties) and 2006 c 255 s 3;

(18) RCW 70.47A.050 (Enrollment to remain within appropriation) and 2006 c 255 s 5;

(19) RCW 70.47A.060 (Rules) and 2006 c 255 s 6;

(20) RCW 70.47A.070 (Reports) and 2006 c 255 s 7;

(21) RCW 70.47A.080 (Small employer health insurance partnership program account) and 2006 c 255 s 8;

(22) RCW 70.47A.090 (State children's health insurance program--Federal waiver request) and 2006 c 255 s 9; and

(23) RCW 70.47A.900 (Captions not law--2006 c 255) and 2006 c 255 s 11.

NEW SECTION. **Sec. 50.** Sections 38 through 42 of this act take effect January 1, 2009."

Renumber remaining sections consecutively and correct any internal references accordingly.

--- END ---

EFFECT: The amendment creates a health insurance exchange for the individual small group market in the state of Washington.

2SSB 5930 - S AMD **171**
By Senator Pflug

PULLED 3/9/2007

On page 46, line 21 of the title amendment, after "41.05.075" strike "and 41.05.540" and insert "41.05.540; 41.05.021; 48.43.005; 48.43.012; 48.43.015; 48.43.018; 48.43.025; and 48.43.035"

On page 47, line 1 of the title amendment, after "sections" insert "repealing RCW 70.47A.06; 70.47A.070; 70.47A.080; 70.47A.090; 70.47A.900; 48.01.260; 48.20.025; 48.20.028; 48.20.029; 48.21.047; 48.43.038; 48.43.041; 48.44.017; 48.44.021; 48.44.022; 48.44.023; 48.44.024; 48.46.062; 48.46.063; 48.46.064; 48.46.068; 70.47A.010; 70.47A.020; 70.47A.030; 70.47A.040; and 70.47A.050

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