6089 WM AMD ADOPTED 3/5/92

SB 6089 - S COMM AMD
By Committee on Ways & Means

ADOPTED AS AMENDED 3/5/92
MADE MOOT BY SENATOR WEST'S AMENDMENT

Strike everything after the enacting clause and insert the following:

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"PART I - HEALTH CARE COST AND ACCESS COMMISSION"

"NEW SECTION. **Sec. 1.** DUTIES AND RESPONSIBILITIES. In addition to the duties and responsibilities specified in House Concurrent Resolution No. 4443 adopted by the legislature in 1990, the health care

cost and access commission authorized therein shall in its report to the legislature and the governor on November 1, 1992, make recommendations on the following:

(1) Recommend proposed alternative uniform benefit plans that the legislature should consider, including estimates of the cost of each alternative plan and recommendations on copayments, deductibles, and premium sharing that should be included;

(2) Analyze the effects and implications of the Employee's Retirement Income Security Act (ERISA) self-funding provisions and the need for changes in federal law;

(3) In addition, the health care commission has the duty to examine the following and report to the legislature on recommendations for legislation:

(a) In order to meet the health needs of the citizenry, it is critical to organize the foundation for financing and providing community-based long-term care and support services through an integrated, comprehensive system that promotes human dignity and recognizes the individuality of all functionally disabled persons. This system shall be available, accessible, and responsive to all citizens based upon an assessment of their functional disabilities. The legislature recognizes that families, volunteers, and community organizations are absolutely essential for delivery of effective and efficient community-based, long-term care and support services and that this private and public service infrastructure should be supported and strengthened. Further, it is important to provide secured benefits assurance in perpetuity without requiring family or program beneficiary impoverishment for service eligibility.

(b) Recognizing that financial stability is essential to success of a comprehensive long-term care system and that current and future demands are exceeding available financial resources, a dedicated fund

comprised of state general funds, matching federal funds, public insurance funds, and sliding fee contributions by program beneficiaries needs be established.

(c) It is the intent of this chapter that the Washington state legislature develop a program and financial structure for the functionally disabled as suggested in this section and adopt the necessary legislation no later than the adjournment of the 1994 regular session of the legislature."

"NEW SECTION. **Sec. 2.** The health care commission, with the assistance of the insurance commissioner, shall conduct an examination of private long-term care insurance. The commission and the commissioner shall jointly appoint a committee to examine and propose recommendations to the legislature on joint underwriting for private long-term care insurance."

"PART II - BASIC HEALTH PLAN"

"**Sec. 3.** RCW 70.47.010 and 1987 1st ex.s. c 5 s 3 are each amended to read as follows:

(1) The legislature finds that:

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

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

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women who are an especially vulnerable population, along with their children, and who need greater access to managed health care.

(2) The purpose of this chapter is to provide or make available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents under sixty-five years of age not otherwise eligible for medicare with gross family income at or below ((~~two~~)) three hundred percent of the federal poverty guidelines who share in a portion of the cost or who pay the full cost of receiving basic health care services from a managed health care system.

(3) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(4) ((~~The program authorized under this chapter is strictly limited in respect to the total number of individuals who may be allowed to participate and the specific areas within the state where it may be established. All such restrictions or limitations shall remain in full force and effect until quantifiable evidence based upon the actual operation of the program, including detailed cost benefit analysis, has been presented to the legislature and the legislature, by specific act at that time, may then modify such limitations~~))

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

(b) As a consequence, the legislature intends to make the program available to individuals with incomes below three hundred percent of federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the program if it is done at no cost to the state. It is also the intent of the legislature to allow employers and other financial sponsors to assist such individuals purchase health care through the program."

"**Sec. 4.** RCW 70.47.020 and 1987 1st ex.s. c 5 s 4 are each amended to read as follows:

As used in this chapter:

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

(2) "Administrator" means the Washington basic health plan administrator.

(3) "Managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any

combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

(4) "Enrollee" means an individual, or an individual plus the individual's spouse and/or dependent children, all under the age of sixty-five and not otherwise eligible for medicare, who resides in an area of the state served by a managed health care system participating in the plan, ((~~whose gross family income at the time of enrollment does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services,~~)) who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan. Nonsubsidized enrollees shall be considered enrollees unless otherwise specified.

(5) "Nonsubsidized enrollee" means an enrollee who pays the full premium for participation in the plan and shall not be eligible for any subsidy from the plan.

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

((~~(6)~~)) (7) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an enrollee makes to the plan as consideration for enrollment in the plan.

((~~(7)~~)) (8) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care

system, that is based upon the enrollment of enrollees in the plan and in that system."

"**Sec. 5.** RCW 70.47.030 and 1991 sp.s. c 13 s 68 and 1991 sp.s. c 4 s 1 are each reenacted and amended to read as follows:

(1) The basic health plan trust account is hereby established in the state treasury. ((~~All~~)) Any nongeneral fund-state funds collected for this program shall be deposited in the basic health plan trust account and may be expended without further appropriation. Moneys in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administering the plan. After July 1, 1991, the administrator shall not expend or encumber for an ensuing fiscal period amounts exceeding ninety-five percent of the amount anticipated to be spent for purchased services during the fiscal year.

(2) The basic health plan subscription account is created in the custody of the state treasurer. All receipts from amounts due under RCW 70.47.060 (10) and (11) shall be deposited into the account. Funds in the account shall be used exclusively for the purposes of this chapter, including payments to participating managed health care systems on behalf of enrollees in the plan and payment of costs of administrating the plan. The account is subject to allotment procedures under chapter 43.88 RCW, but no appropriation is required for expenditures.

(3) The administrator shall take every precaution to see that none of the funds in the separate accounts created in this section or that any premiums paid either by subsidized or nonsubsidized enrollees are commingled in any way, except that the administrator may combine funds

designated for administration of the plan into a single administrative account."

"**Sec. 6.** RCW 70.47.060 and 1991 sp.s. c 4 s 2 and 1991 c 3 s 339 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, and other services that may be necessary for basic health care, which enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care, shall include all services necessary for prenatal, postnatal, and well-child care, and shall include a separate schedule of basic health care services for children, eighteen years of age and younger, for those enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.42.080, and such other factors as the administrator deems appropriate.

(2) To design and implement a structure of periodic premiums due the administrator from enrollees that is based upon gross family income, giving appropriate consideration to family size as well as the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for the plan.

(a) An employer or other financial sponsor may, with the approval of the administrator, pay the premium on behalf of any enrollee, by

arrangement with the enrollee and through a mechanism acceptable to the administrator, but in no case shall the payment made on behalf of the enrollee exceed eighty percent of total premiums due from the enrollee.

(b) Premiums due from nonsubsidized enrollees, who are not otherwise eligible to be enrollees, shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees.

(3) To design and implement a structure of nominal copayments due a managed health care system from enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(4) To design and implement, in concert with a sufficient number of potential providers in a discrete area, an enrollee financial participation structure, separate from that otherwise established under this chapter, that has the following characteristics:

(a) Nominal premiums that are based upon ability to pay, but not set at a level that would discourage enrollment;

(b) A modified fee-for-services payment schedule for providers;

(c) Coinsurance rates that are established based on specific service and procedure costs and the enrollee’s ability to pay for the care. However, coinsurance rates for families with incomes below one hundred twenty percent of the federal poverty level shall be nominal. No coinsurance shall be required for specific proven prevention programs, such as prenatal care. The coinsurance rate levels shall not have a measurable negative effect upon the enrollee’s health status; and

(d) A case management system that fosters a provider-enrollee relationship whereby, in an effort to control cost, maintain or improve

the health status of the enrollee, and maximize patient involvement in her or his health care decision-making process, every effort is made by the provider to inform the enrollee of the cost of the specific services and procedures and related health benefits.

The potential financial liability of the plan to any such providers shall not exceed in the aggregate an amount greater than that which might otherwise have been incurred by the plan on the basis of the number of enrollees multiplied by the average of the prepaid capitated rates negotiated with participating managed health care systems under RCW 70.47.100 and reduced by any sums charged enrollees on the basis of the coinsurance rates that are established under this subsection.

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

(6)(a) To limit the payment of a subsidy to an enrollee, as defined in RCW 70.47.020, whose gross family income at the time of enrollment does not exceed twice the federal poverty level adjusted for family size and determined annually by the federal department of health and human services.

(b) To limit participation of nonsubsidized enrollees in the plan to those whose family incomes at the time of enrollment does not exceed three times the federal poverty level adjusted for family size and determined annually by the federal department of health and human services.

(7) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080.

In the selection of any area of the state for the initial operation of the plan, the administrator shall take into account the levels and rates of unemployment in different areas of the state, the need to provide basic health care coverage to a population reasonably representative of the portion of the state's population that lacks such coverage, and the need for geographic, demographic, and economic diversity.

((~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts with managed health care systems in discrete geographic areas within at least five congressional districts.~~

~~(7)~~)) (8) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state.

((~~(8)~~)) (9) To receive periodic premiums from enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

((~~(9)~~)) (10) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as

may be necessary, and to determine, upon application and at least annually thereafter, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. An enrollee who remains current in payment of the sliding-scale premium, as determined under subsection (2) of this section, and whose gross family income has risen above ((~~twice~~)) three times the federal poverty level, may continue enrollment unless and until the enrollee's gross family income has remained above ((~~twice~~)) three times the poverty level for six consecutive months, by making payment at the unsubsidized rate required for the managed health care system in which he or she may be enrolled plus the administrative cost of providing the plan to that enrollee. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to re-enroll in the plan.

((~~(10)~~)) (11) To accept applications from small business owners on behalf of themselves and their employees, spouses, and dependents who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. Such businesses shall have less than fifty employees and enrollment shall be limited to those not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of

health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes. No enrollee of a small business group shall be eligible for any subsidy from the plan and at no time shall the administrator allow the credit of the state or funds from the trust account to be used or extended on their behalf.

(12) To accept applications from individuals residing in areas serviced by the plan, on behalf of themselves and their spouses and dependent children, under sixty-five years of age and not otherwise eligible for medicare, whose gross family income at the time of enrollment does not exceed three times the federal poverty level as adjusted for family size and determined by the federal department of health and human services, who wish to enroll in the plan at no cost to the state and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. Any such nonsubsidized enrollees must pay the amount negotiated by the administrator with the participating managed health care system and the administrative cost of providing the plan to such nonsubsidized enrollees and shall not be eligible for any subsidy from the plan.

(13) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with

participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant. In determining the rate to be paid to a contractor, the administrator shall strive to assure that the rate does not result in adverse cost shifting to other private payers of health care.

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

((~~(12)~~)) (15) To monitor the access that state residents have to adequate and necessary health care services, determine the extent of any unmet needs for such services or lack of access that may exist from time to time, and make such reports and recommendations to the legislature as the administrator deems appropriate.

((~~(13)~~)) (16) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures

consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

((~~(14)~~)) (17) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

((~~(15)~~)) (18) To provide, consistent with available resources, technical assistance for rural health activities that endeavor to develop needed health care services in rural parts of the state."

"**Sec. 7.** RCW 70.47.080 and 1987 1st ex.s. c 5 s 10 are each amended to read as follows:

On and after July 1, 1988, the administrator shall accept for enrollment applicants eligible to receive covered basic health care services from the respective managed health care systems which are then participating in the plan. ((~~The administrator shall not allow the total enrollment of those eligible for subsidies to exceed thirty thousand.~~))

Thereafter, ((~~total~~)) the average monthly enrollment of those eligible for subsidies during any biennium shall not exceed the number established by the legislature in any act appropriating funds to the plan, and total subsidized enrollment shall not result in expenditures that exceed the total amount that has been made available by the legislature in any act appropriating funds to the plan.

((~~Before July 1, 1988, the administrator shall endeavor to secure participation contracts from managed health care systems in discrete geographic areas within at least five congressional districts of the state and in such manner as to allow residents of both urban and rural areas access to enrollment in the plan. The administrator shall make a special effort to secure agreements with health care providers in one such area that meets the requirements set forth in RCW 70.47.060(4).~~))

The administrator shall at all times closely monitor growth patterns of enrollment so as not to exceed that consistent with the orderly development of the plan as a whole, in any area of the state or in any participating managed health care system. The annual or biennial enrollment limitations derived from operation of the plan under this section do not apply to nonsubsidized enrollees as defined in RCW 70.47.020(6)."

"**Sec. 8.** RCW 70.47.120 and 1987 1st ex.s. c 5 s 14 are each amended to read as follows:

In addition to the powers and duties specified in RCW 70.47.040 and 70.47.060, the administrator has the power to enter into contracts for the following functions and services:

(1) With public or private agencies, to assist the administrator in her or his duties to design or revise the schedule of covered basic health care services, and/or to monitor or evaluate the performance of participating managed health care systems.

(2) With public or private agencies, to provide technical or professional assistance to health care providers, particularly public or private nonprofit organizations and providers serving rural areas, who show serious intent and apparent capability to participate in the plan as managed health care systems.

(3) With public or private agencies, including health care service contractors registered under RCW 48.44.015, and doing business in the state, for marketing and administrative services in connection with participation of managed health care systems, enrollment of enrollees, billing and collection services to the administrator, and other administrative functions ordinarily performed by health care service contractors, other than insurance except that the administrator may purchase or arrange for the purchase of reinsurance, or self-insure for

reinsurance, on behalf of its participating managed health care systems. Any activities of a health care service contractor pursuant to a contract with the administrator under this section shall be exempt from the provisions and requirements of Title 48 RCW."

"NEW SECTION. **Sec. 9.** SUNSET REPEALED. The following acts or parts of acts are each repealed:

(1) RCW 43.131.355 and 1987 1st ex.s. c 5 s 24; and

(2) RCW 43.131.356 and 1987 1st ex.s. c 5 s 25."

"PART III - BASIC HEALTH PLAN ENROLLMENT EXPANSION"

"NEW SECTION. **Sec. 10.** BASIC HEALTH PLAN ENROLLMENT EXPANSION. The state basic health plan is authorized to expand the number of state-subsidized enrollments from up to twenty-four thousand, as is specified in 1991-93 biennial operating budget, section 230, chapter 16, Laws of 1991 sp. sess., to an enrollment limit of up to sixty-four thousand. If specific funding for the purposes of this section, referencing this act by bill number, is not provided by June 30, 1992, in the omnibus appropriations act, this section shall become null and void."

"PART IV - HEALTH DATA COLLECTION"

"**Sec. 11.** RCW 70.170.010 and 1989 1st ex.s. c 9 s 501 are each amended to read as follows:

(1) The legislature finds and declares that there is a need for health care information that helps the general public understand health care issues and how they can be better consumers and that is useful to purchasers, payers, and providers in making health care choices,

determining and monitoring the quality of health care services and ((~~negotiating payments~~)) making health care purchasing decisions. It is the purpose and intent of this chapter to establish a ((~~hospital~~)) personal health services data collection, storage, and retrieval system which supports these data needs and which also provides public officials and others engaged in the development of state health policy~~,~~ the purchasing of health care services, and the monitoring of the health care system for quality the information necessary for the analysis of health care issues.

(2) The legislature finds that rising health care costs and access to health care services are of vital concern to the people of this state. It is, therefore, essential that strategies be explored that moderate health care costs and promote access to health care services.

(3) The legislature further finds that access to health care is among the state's goals and the provision of such care should be among the purposes of health care providers and facilities. Therefore, the legislature intends that charity care requirements and related enforcement provisions for hospitals be explicitly established.

(4) The lack of reliable statistical information about the delivery of charity care is a particular concern that should be addressed. ((~~It is the~~)) A purpose ((~~and intent~~)) of this chapter is to require hospitals to provide, and report to the state, charity care to persons with acute care needs, and to have a state agency both monitor and report on the relative commitment of hospitals to the delivery of charity care services, as well as the relative commitment of public and private purchasers or payers to charity care funding.

(5) It is further the intent of this chapter to designate the department of health as depository agency for personal health data collected pursuant to goals established in this section."

"**Sec. 12.** RCW 70.170.030 and 1989 1st ex.s. c 9 s 503 are each amended to read as follows:

(1) There is created the health care access and cost control council within the department of health consisting of the following: The director of the department of labor and industries; the administrator of the health care authority; the secretary of social and health services; the administrator of the basic health plan; a person representing the governor on matters of health policy; the secretary of health; and ((~~one member from the public-at-large to be selected by the governor who shall represent individual consumers of health care~~)) five public members, to be selected by the governor, comprised of two health care providers, two payers of health care services, and one member from the public-at-large who shall represent individual consumers of health care. The public member-at-large shall not have any fiduciary obligation to any health care facility or any financial interest in the provision of health care services. Members employed by the state shall serve without pay and participation in the council's work shall be deemed performance of their employment. The public members shall be compensated in accordance with RCW 43.03.240 and shall be reimbursed for related travel expenses in accordance with RCW 43.03.050 and 43.03.060.

(2) A member of the council designated by the governor shall serve as chairman. The council shall elect a vice-chairman from its members biennially. Meetings of the council shall be held as frequently as its duties require. The council shall keep minutes of its meetings and adopt procedures for the governing of its meetings, minutes, and transactions.

(3) ((~~Four~~)) Seven members shall constitute a quorum, but a vacancy on the council shall not impair its power to act. No action of the

council shall be effective unless ((~~four~~)) seven members concur therein."

"**Sec. 13.** RCW 70.170.040 and 1989 1st ex.s. c 9 s 504 are each amended to read as follows:

(1) In order to advise the department and the board of health in preparing executive request legislation and the state health report according to RCW 43.20.050, and, in order to ((~~represent the public interest~~)) assist the department to establish a depository of personal health services data, the council shall monitor and evaluate ((~~hospital and related~~)) health care services consistent with RCW 70.170.010. In fulfilling its responsibilities, the council shall have complete access to all the department's data and information systems.

(2) The council shall advise the department on the hospital and health care services data collection system required by this chapter.

(3) The council, in addition to participation in the development of the state health report, shall, from time to time, report to the governor and the appropriate committees of the legislature with proposed changes in ((~~hospital and related~~)) health care services, consistent with the findings in RCW 70.170.010.

(4) The department ((~~may~~)) shall undertake, with advice from the council and within available funds, the following studies and activities:

(a) Recommendations regarding health care cost containment, and the assurance of access and maintenance of adequate standards of care;

(b) Analysis of the effects of various payment methods on health care access and costs;

(c) The utility of the certificate of need program and related health planning process;

(d) Methods of permitting the inclusion of advance medical technology on the health care system, while controlling inappropriate use;

(e) The appropriateness of allocation of health care services;

(f) Professional liabilities on health care access and costs, to include:

(i) Quantification of the financial effects of professional liability on health care reimbursement;

(ii) Determination of the effects, if any, of nonmonetary factors upon the availability of, and access to, appropriate and necessary basic health services such as, but not limited to, prenatal and obstetrical care; and

(iii) Recommendation of proposals that would mitigate cost and access impacts associated with professional liability.

((~~The department shall report its findings and recommendations to the governor and the appropriate committees of the legislature not later than July 1, 1991.~~)) (g) Strategies to engage in data collection activities necessary to pursue the objectives established under RCW 70.170.010;

(h) Strategies to standardize and coordinate existing state agency health care data systems necessary to pursue objectives established under RCW 70.170.010; and

(i) Strategies, to the extent possible, to develop data sharing activities between the public and private sectors on personal health data and to incorporate such data into the data repository consistent with objectives established under RCW 70.170.010."

"PART V - PRACTICE PARAMETERS AND RISK MANAGEMENT PROTOCOLS"

"NEW SECTION. **Sec. 14.** LEGISLATIVE INTENT. The legislature finds that improving the quality of health services provided by health care professionals is an important public policy objective. It is in the public's interest to assure that health care professionals utilize diagnostic procedures and treatments that are appropriate and efficacious.

The legislature further finds that the state of health care technology and knowledge is increasingly advancing to the state where it is possible to assess the effectiveness and appropriateness of specific treatments and measure the quality of health care provided to individuals. Such advances will permit a more systematic monitoring and evaluation of services delivered by health care professionals towards the goals of assuring appropriate and effective utilization of such services.

The legislature finds and declares that practice guidelines or parameters and risk management protocols can be an effective means for assuring appropriate and efficacious treatments. Public policy should be established to encourage their development and use."

"NEW SECTION. **Sec. 15.** DEPARTMENT ACTIVITIES. The department shall consult with health care providers, purchasers, health professional regulatory authorities under RCW 18.130.040, appropriate research and clinical experts, and consumers of health care services to identify specific practice areas where practice parameters and risk management protocols can reasonably be developed. The department shall make a report, including recommendations for legislation, to the governor and appropriate legislative committees in the senate and house of representatives by December 15, 1992, on the following:

(1) The health care services where practice parameters and risk management protocols can reasonably be developed given the current state of knowledge;

(2) The use of practice parameters and risk management protocols in quality assurance and as standards in malpractice litigation;

(3) Practical issues involved in developing practice parameters and risk management protocols, including needed data bases and monitoring capabilities;

(4) Appropriate roles for the public and private interests in the development and implementation of practice parameters and risk management protocols, including the role of health professional credentialing and disciplinary authorities, purchasers, consumers, health care research institutions, and others; and

(5) A strategy for the development of practice parameters and risk management protocols."

"PART VI - HEALTH CARE MALPRACTICE REFORM"

"**Sec. 16.** RCW 7.70.070 and 1975-’76 2nd ex.s. c 56 s 12 are each amended to read as follows:

The court shall, in any action under this chapter, determine the reasonableness of each party’s fixed attorneys fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services((~~;~~

~~(8) Whether the fee is fixed or contingent~~))."

"NEW SECTION. **Sec. 17.** CONTINGENT ATTORNEYS' FEES LIMITED. (1) As used in this section:

(a) "Contingency fee agreement" means an agreement that an attorney's fee is dependent or contingent, in whole or in part, upon successful prosecution or settlement of a claim or action, or upon the amount of recovery.

(b) "Properly chargeable disbursements" means reasonable expenses incurred and paid by an attorney on a client's behalf in prosecuting or settling a claim or action.

(c) "Recovery" means the amount to be paid to an attorney's client as a result of a settlement or money judgment.

(2) In a claim or action filed under this chapter for personal injury or wrongful death based upon the alleged conduct of another, if an attorney enters into a contingency fee agreement with his or her client and if a money judgment is awarded to the attorney's client or the claim or action is settled, the attorney's fee shall not exceed the amounts set forth in (a) and (b) of this subsection:

(a) Not more than forty percent of the first five thousand dollars recovered, then not more than thirty-five percent of the amount more

than five thousand dollars but less than twenty-five thousand dollars, then not more than twenty-five percent of the amount of twenty-five thousand dollars or more but less than two hundred fifty thousand dollars, then not more than twenty percent of the amount of two hundred fifty thousand dollars or more but less than five hundred thousand dollars, and not more than ten percent of the amount of five hundred thousand dollars or more.

(b) As an alternative to (a) of this subsection, not more than one-third of the first two hundred fifty thousand dollars recovered, not more than twenty percent of an amount more than two hundred fifty thousand dollars but less than five hundred thousand dollars, and not more than ten percent of an amount more than five hundred thousand dollars.

(3) The fees allowed in subsection (2) of this section are computed on the net sum of the recovery after deducting from the recovery the properly chargeable disbursements. In computing the fee, the costs as taxed by the court are part of the amount of the money judgment. In the case of a recovery payable in installments, the fee is computed using the present value of the future payments.

(4) A contingency fee agreement made by an attorney with a client must be in writing and must be executed at the time the client retains the attorney for the claim or action that is the basis for the contingency fee agreement. An attorney who fails to comply with this subsection is barred from recovering a fee in excess of the lowest fee available under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable.

(5) An attorney shall provide a copy of a contingency fee agreement to the client at the time the contingency fee agreement is executed. An attorney shall include his or her usual and customary hourly rate of compensation in a contingency fee agreement.

(6) An attorney who enters into a contingency fee agreement that violates subsection (2) of this section is barred from recovering a fee in excess of the attorney's reasonable actual attorney fees based on his or her usual and customary hourly rate of compensation, up to the lowest amount allowed under subsection (2) of this section, but the other provisions of the contingency fee agreement remain enforceable."

"NEW SECTION. **Sec. 18.** A new section is added to chapter 7.70 RCW to read as follows:

Sections 16 and 17 of this act shall apply to causes of action which arise on or after July 1, 1992."

"NEW SECTION. **Sec. 19.** LEGISLATIVE INTENT. The legislature finds that in *Sofie v. Fibreboard Corp., 112 Wn.2d 636 (1989),* the Washington state supreme court struck down the limit on noneconomic damages enacted by the legislature in 1986, because the court found that the statutory limitation on noneconomic damages interfered with the jury's province to determine damages, and thus violated a plaintiff's constitutionally protected right to trial by jury.

The legislature further finds that reforms in existing law for actions involving fault are necessary and proper to avoid catastrophic economic consequences for state and local governmental entities as well as private individuals and businesses.

Therefore, the legislature declares that to remedy the economic inequities which may arise from *Sofie*, defendants in actions involving fault should be held financially liable in closer proportion to their respective degree of fault. To treat them differently is unfair and inequitable.

It is further the intent of the legislature to partially eliminate causes of action based on joint and several liability as provided by

this act for the purpose of reducing costs associated with the civil justice system."

"NEW SECTION. **Sec. 20.** JOINT AND SEVERAL LIABILITY RESTRICTIONS. (1) For the purposes of this section, the term "economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, cost of obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities. "Economic damages" does not include subjective, nonmonetary losses such as pain and suffering, mental anguish, emotional distress, disability and disfigurement, inconvenience, injury to reputation, humiliation, destruction of the parent-child relationship, the nature and extent of an injury, loss of consortium, society, companionship, support, love, affection, care, services, guidance, training, instruction, and protection.

(2) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which is attributable to every entity which caused the claimant's injuries, including the claimant or person suffering personal injury, defendants, third-party defendants, entities released by the claimant, entities immune from liability to the claimant and entities with any other individual defense against the claimant. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were

acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimant's economic damages.

(3) If a defendant is jointly and severally liable under one of the exceptions listed in subsection (2)(a) or (b) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

(4) This section shall apply to causes of action which arise on or after July 1, 1992."

"NEW SECTION. **Sec. 21.** CERTIFICATE OF MERIT REQUIRED. (1) The claimant's attorney shall file the certificate specified in subsection (2) of this section within thirty days of filing or service, whichever occurs later, for any action for damages arising out of injuries resulting from health care by a person regulated by a disciplinary authority in the state of Washington to practice a health care profession under RCW 18.130.040 or by the state board of pharmacy under chapter 18.64 RCW.

(2) The certificate issued by the claimant's attorney shall declare:

(a) That the attorney has reviewed the facts of the case;

(b) That the attorney has consulted with at least one qualified expert who holds a license, certificate, or registration issued by this state or another state in the same profession as that of the defendant, who practices in the same specialty or subspecialty as the defendant,

and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action;

(c) The identity of the expert and the expert's license, certification, or registration;

(d) That the expert is willing and available to testify to admissible facts or opinions; and

(e) That the attorney has concluded on the basis of such review and consultation that there is reasonable and meritorious cause for the filing of such action.

(3) Where a certificate is required under this section, and where there are multiple defendants, the certificate or certificates must state the attorney's conclusion that on the basis of review and expert consultation, there is reasonable and meritorious cause for the filing of such action as to each defendant.

(4) The provisions of this section shall not be applicable to a plaintiff who is not represented by an attorney.

(5) Violation of this section shall be grounds for either dismissal of the case or sanctions against the attorney, or both, as the court deems appropriate."

"NEW SECTION. **Sec. 22.** EFFECTIVE DATE. Section 21 of this act applies to all actions for damages arising out of injuries resulting from health care filed on or after July 1, 1992."

"NEW SECTION. **Sec. 23.** LEGISLATIVE INTENT. The legislature finds and declares that:

(1) The willingness of volunteer health care providers to offer their services has been increasingly deterred by a perception that they put personal assets at risk in the event of tort actions seeking damages arising from their activities as volunteers;

(2) The contributions of programs, activities, and services to communities is diminished and worthwhile programs, activities, and services are deterred by the unwillingness of volunteer health care providers to serve either as volunteers or as officers, directors, or trustees of nonprofit public and private organizations;

(3) It is in the public interest to strike a balance between the right of a person to seek redress for injury and the right of an individual health care provider to freely give of his or her time and energy without compensation as a volunteer in service to his or her community without fear of personal liability for acts undertaken in good faith absent willful or wanton conduct on the part of the volunteer; and

(4) This chapter is intended to encourage volunteer health care providers to contribute their services for the good of their communities and at the same time provide a reasonable basis for redress of claims which may arise relating to those services."

"NEW SECTION. **Sec. 24.** DEFINITIONS. Unless the context clearly requires otherwise, the definitions in this section apply throughout sections 25 and 26 of this act.

(1) "Volunteer" is a person regulated by a disciplinary authority in the State of Washington to practice a health care profession under RCW 18.130.040, or by the state board of pharmacy under chapter 18.64 RCW, providing health care services for a nonprofit organization, a nonprofit corporation, a hospital, or a governmental entity without compensation, other than reimbursement for actual expenses incurred. The term includes a volunteer serving as a director, officer, trustee, or direct service volunteer.

(2) "Nonprofit organization" is any organization that is exempt from taxation pursuant to section 501(c) of the Internal Revenue Code, 26 U.S.C. Sec. 501(c), as amended.

(3) "Nonprofit corporation" is any corporation that is defined as a nonprofit corporation under Title 24 RCW or that is exempt from taxation pursuant to section 501(a) of the Internal Revenue Code, 26 U.S.C. Sec. 501(a).

(4) "Governmental entity" is any county, city, town, municipality, school district, governmental unit, other special district, similar entity, or any association, authority, board, commission, division, office, officer, task force, or other agency of the state."

"NEW SECTION. **Sec. 25.** VOLUNTEER HEALTH CARE PROVIDER IMMUNITY. (1) Any volunteer shall be immune from civil liability in any action on the basis of any act or omission of a volunteer resulting in damage or injury if:

(a) The volunteer was acting in good faith and within the scope of the volunteer’s official functions and duties for a nonprofit organization, a nonprofit corporation, hospital, or a governmental entity; and

(b) The damage or injury was not caused by willful and wanton misconduct by the volunteer.

(2) In any suit against a nonprofit organization, nonprofit corporation, or a hospital for civil damages based upon the negligent act or omission of a volunteer, proof of such act or omission shall be sufficient to establish the responsibility of the organization therefor under the doctrine of respondeat superior, notwithstanding the immunity granted to the volunteer with respect to any act or omission included under subsection (1) of this section."

"NEW SECTION. **Sec. 26.** INJURIES ARISING FROM AUTO ACCIDENTS NOT EXEMPTED. Notwithstanding section 25 of this act, a plaintiff may sue and recover civil damages from a volunteer based upon a negligent act or omission involving the operation of a motor vehicle during an activity, except that the amount recovered from such volunteer may not exceed the limits of applicable insurance coverage maintained by or on behalf of such volunteer with respect to the negligent operation of a motor vehicle in such circumstances."

"NEW SECTION. **Sec. 27.** APPLICATION. Sections 23 through 26 of this act apply to all causes of action commenced on or after the effective date of this section, regardless of when the cause of action may have arisen. To this extent, sections 23 through 26 of this act apply retroactively, but in all other respects sections 23 through 26 of this act apply prospectively."

"PART VII - HEALTH CARE PROVIDER CONFLICT OF FINANCIAL INTEREST"

"NEW SECTION. **Sec. 28.** LEGISLATIVE INTENT. The legislature finds that there is a growing practice of health care professionals having financial interest in laboratory and other services. The legislature further finds that such practices may result in overutilization of health care services and excessive costs to individuals, third-party payers, and the health care system.

The legislature declares that the notification of patients and third-party payers about these referral practices can make them more aware of such practices and allow payers to track providers who through referrals overutilize services for financial reasons."

"**Sec. 29.** RCW 19.68.010 and 1973 1st ex.s. c 26 s 1 are each amended to read as follows:

It shall be unlawful for any person, firm, corporation or association, whether organized as a cooperative, or for profit or nonprofit, to pay, or offer to pay or allow, directly or indirectly, to any person licensed by the state of Washington to engage in the practice of medicine and surgery, drugless treatment in any form, dentistry, or pharmacy and it shall be unlawful for such person to request, receive or allow, directly or indirectly, a rebate, refund, commission, unearned discount or profit by means of a credit or other valuable consideration in connection with the referral of patients to any person, firm, corporation or association, or in connection with the furnishings of medical, surgical or dental care, diagnosis, treatment or service, on the sale, rental, furnishing or supplying of clinical laboratory supplies or services of any kind, drugs, medication, or medical supplies, or any other goods, services or supplies prescribed for medical diagnosis, care or treatment: PROVIDED, That ownership of a financial interest in any firm, corporation or association which furnishes any kind of clinical laboratory or other services prescribed for medical, surgical, or dental diagnosis shall not be prohibited under this section where (1) the referring practitioner affirmatively discloses to the patient and the patient's insurer in writing, the fact that such practitioner has a financial interest in such firm, corporation, or association; (2) the referring practitioner provides the patient with a list of effective alternative facilities, informs the patient that he or she has the option to use one of the alternative facilities, and assures the patient that he or she will not be treated differently by the referring practitioner if the patient chooses one of the alternative facilities; and (3) that such firm, corporation, or

association shall also notify the insurer at the time of billing for said services.

Any person violating the provisions of this section is guilty of a misdemeanor."

"PART VIII - STANDARDIZED HEALTH CARE INSURANCE CLAIM FORMS"

"NEW SECTION. **Sec. 30.** A new section is added to chapter 48.20 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1994, all disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 39 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 31.** A new section is added to chapter 48.21 RCW to read as follows:

APPLICATION TO DISABILITY INSURANCE POLICIES. (1) After January 1, 1994, all group disability insurance policies that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this

subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 39 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 32.** A new section is added to chapter 48.44 RCW to read as follows:

APPLICATION TO HEALTH CARE INSURANCE CONTRACTS. (1) After January 1, 1994, all health care insurance contracts that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 39 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 33.** A new section is added to chapter 48.46 RCW to read as follows:

APPLICATION TO HEALTH MAINTENANCE AGREEMENTS. (1) After January 1, 1994, all health maintenance agreements that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform billing (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 39 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 34.** A new section is added to chapter 48.84 RCW to read as follows:

APPLICATION TO LONG-TERM CARE PROVIDERS. (1) After January 1, 1994, all providers of long-term care that provide coverage for hospital or medical expenses shall use for all billing purposes in either paper or electronic format either the health care financing administration (HCFA) 1500 form, or its successor, or the uniform bill (UB) 82 form, or its successor. For billing purposes, this subsection does not apply to pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services.

(2) As of January 1, 1994, the forms developed under section 39 of this act shall be used by providers of health care and carriers under this chapter."

"NEW SECTION. **Sec. 35.** A new section is added to chapter 41.05 RCW to read as follows:

APPLICATION TO STATE HEALTH CARE AUTHORITY. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided through the health care authority. The forms developed under section 39 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 36.** A new section is added to chapter 43.20A RCW to read as follows:

APPLICATION TO MEDICAID PROGRAM. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided by the department. The forms developed under section 39 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 37.** A new section is added to Title 51 RCW to read as follows:

APPLICATION TO LABOR AND INDUSTRIES. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided under this title. The forms developed under section 39 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 38.** APPLICATION TO BASIC HEALTH PLAN. After July 1, 1994, the health care financing administration (HCFA) 1500 form, or its successor, and the uniform billing (UB) 82 form, or its successor, shall be used in either paper or electronic format for state-paid health care services provided under the basic health plan. The forms developed under section 39 of this act shall be used for billing purposes for pharmacists, dentists, home health/nursing services, eyeglasses, transportation, or vocational services."

"NEW SECTION. **Sec. 39.** A new section is added to chapter 41.05 RCW to read as follows:

JOINT AGENCY RULES. By January 1, 1993, the basic health plan administrator, the health care authority administrator, the secretary of social and health services, and the director of the department of labor and industries shall jointly develop and adopt by rule in paper and electronic format billing forms to be used by pharmacists, dentists, home health/nursing services, eyeglasses, transportation, and vocational services. These forms shall be made available to providers of health care coverage licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.84 RCW."

"PART IX - HEALTH INSURANCE PREMIUMS TAX EXEMPTION"

"**Sec. 40.** RCW 48.14.022 and 1987 c 431 s 23 are each amended to read as follows:

(1) The taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for policies of insurance issued under RCW 48.41.010 through 48.41.210.

(2) Until July 1, 1994, the taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for policies of insurance issued under RCW 48.21.045.

(3) In computing tax due under RCW 48.14.020, there may be deducted from taxable premiums the amount of any assessment against the taxpayer under RCW 48.41.010 through 48.41.210. Any portion of the deduction allowed in this section which cannot be deducted in a tax year without reducing taxable premiums below zero may be carried forward and deducted in successive years until the deduction is exhausted."

"PART X - SMALL BUSINESS HEALTH CARE INSURANCE REFORM"

"NEW SECTION. **Sec. 41.** SHORT TITLE. This chapter shall be known and may be cited as the small employer health insurance availability act."

"NEW SECTION. **Sec. 42.** PURPOSE. The purpose and intent of this chapter is to promote the availability of health insurance coverage to small employers regardless of the health status or claims experience, to prevent abusive rating practices, to require disclosure of rating practices to purchasers, to establish rules regarding renewability of coverage, to establish limitation on the use of preexisting condition exclusions, to provide for development of a basic health benefit plan to be offered to all small employers, to provide for establishment of an allocation program, and to improve the overall fairness and efficiency of the small group health insurance market.

This chapter is not intended to provide a solution to the problem of affordability of health care or health insurance."

"NEW SECTION. **Sec. 43.** DEFINITIONS. As used in this chapter:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries, or other individual acceptable to the commissioner, that a small employer carrier is in compliance with the provisions of section 45 of this act, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Allocating carrier" means a small employer carrier participating in the allocation program under section 48 of this act.

(3) "Base premium rate" means, as to a rating period, the lowest premium rate charged or that could have been charged under the rating system by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(4) "Basic health benefit plan" means a lower cost health benefit plan developed under section 49 of this act.

(5) "Board" means the board of directors of the Washington state health insurance pool, as established by chapter 48.41 RCW.

(6) "Carrier" means any entity that provides health insurance in Washington state. For the purposes of this chapter, carrier includes an insurance company, health care service contractor, fraternal benefit society, health maintenance organization, multiple employer welfare arrangements, or any person or entity that writes, issues, or administers health benefit plans in Washington state.

(7) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that claim experience, health status, and duration of coverage shall not be case characteristics for the purposes of this chapter.

(8) "Commissioner" means the insurance commissioner as defined in RCW 48.02.010.

(9) "Committee" means the health benefit plan committee created under section 49 of this act.

(10) "Dependent" means the spouse or an unmarried child under the age of nineteen years or an unmarried child who is a full-time student under the age of twenty-three years who is financially dependent upon an eligible employee or a child of any age who is medically certified as disabled and dependent of an eligible employee.

(11) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty or more hours, who has met any applicable requirement of the employer as to the period of employment before an employee is eligible for health benefits coverage. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietary, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis.

(12) "Established geographic service area" means a geographical area, as approved by the commissioner and based on the carrier's certificate of authority to transact business in Washington state, within which the carrier is authorized to provide coverage.

(13) "Health benefit plan" means any hospital or medical policy or certificate, health care service contract, health maintenance organization subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by any other benefit arrangement subject to this chapter. The term does not include accident only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

(14) "Index rate" means, as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

(15) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period provided under the terms of the health benefit plan, provided that such initial enrollment period is a

period of at least thirty days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

(i) The individual was covered under qualifying previous coverage at the time the individual was eligible to enroll;

(ii) The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage, death of a spouse, or divorce;

(iii) The individual requests enrollment within thirty days after termination of the qualifying previous coverage;

(b) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee’s health benefit plan and request for enrollment is made within thirty days after issuance of the court order.

(16) "New business premium rate" means, as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Plan of operation" means the plan of operation of the allocation program established under section 48 of this act.

(18) "Premium" means all moneys paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(19) "Program" means the Washington small employer allocation program established under section 48 of this act.

(20) "Rating period" means the calendar year period for which premium rates established by a small employer carrier are presumed to be in effect.

(21) "Restricted network provision" means any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to chapter 48.44 or 48.46 RCW to provide health care services to covered individuals.

(22) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least three unrelated eligible employees but no more than twenty-five eligible employees, the majority of whom were employed within Washington state. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for proposes of state taxation, shall be considered one employer.

(23) "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers in Washington state.

(24) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(25) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or medicaid;

(b) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan that is subject to the insurance regulations of Washington state; or

(c) An individual health insurance policy, including coverage issued by an insurance company, health care service contractor, fraternal benefit society, health maintenance organization, multiple employer welfare arrangement, or any person or entity that writes, issues, or administers health benefit plans in Washington state, that provides benefits similar to or exceeding benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least six months."

"NEW SECTION. **Sec. 44.** APPLICABILITY AND SCOPE. This chapter shall apply to any health benefit plan that provides coverage to the employees of a small employer in Washington state if any of the following conditions are met:

(1) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(2) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(3) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125, or section 106 of the United States Internal Revenue Code.

(4)(a) Except as provided in (b) of this subsection, for the purposes of this chapter, carriers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier and any restrictions or limitations imposed by this chapter

shall apply as if all health benefit plans issued to small employers in Washington state by such affiliated carriers were issued by one carrier.

(b) An affiliated carrier that is a health maintenance organization having a certificate of registration under chapter 48.46 RCW may be considered a separate carrier for the purposes of this chapter.

(c) Unless otherwise authorized by the commissioner, a small employer carrier shall not enter into one or more ceding arrangements with respect to health benefit plans issued to small employers in Washington state if such arrangements would result in less than fifty percent of the insurance obligation or risk for such health benefit plans being retained by the ceding carrier."

"NEW SECTION. **Sec. 45.** RESTRICTIONS RELATING TO PREMIUM RATES. (1) Premium rates for health benefit plans subject to this chapter shall be subject to the following provisions:

(a) The premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system, shall not vary from the index rate by more than twenty-five percent of the index rate.

(b) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a

percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment, not to exceed fifteen percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, and duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual.

(c) Adjustments in rates for claim experience, health status, and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(d) A small employer carrier may utilize industry as a case characteristic in establishing premium rates, provided that the highest rate factor associated with any industry classification shall not exceed the lowest rate factor associated with any industry classification by more than fifteen percent.

(e) In the case of health benefit plans issued prior to the effective date of this act, a premium rate for a rating period may exceed the ranges set forth in (a) of this subsection for a period of three years following the effective date of this act. In such cases, the percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the

small employer carrier shall use the percentage change in the base premium rate, provided that such change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual.

(f)(i) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers. Rating factors shall produce premiums for identical groups that differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

(ii) A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this subsection, a health benefit plan that utilizes a restricted provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the restricted provider network results in substantial differences in claims costs.

(h) A small employer carrier shall not use case characteristics other than age, gender, industry, geographic area, family composition, and group size without prior approval of the commissioner.

(i) The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including:

(i) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribing the manner in which case characteristics may be used by small employer carriers.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a health benefit plan. A small employer carrier shall not offer to transfer a small employer into or out of a health benefit plan unless such offer is made to transfer all small employers with the same health benefit plan without regard to case characteristics, claim experience, health status, or duration of coverage.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) of this section as to the premium rates applicable to one or more small employers of a small employer carrier for one or more rating periods upon a finding by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier’s right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(c) The provision relating to renewability of policies and contracts; and

(d) The provisions relating to any preexisting condition.

(5)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in (a) of this subsection available to the commissioner upon request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the office except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction."

"NEW SECTION. **Sec. 46.** RENEWABILITY OF COVERAGE. (1) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(a) Nonpayment of required premiums;

(b) Fraud or misrepresentation by the small employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(c) Noncompliance with the carrier's minimum participation requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) Repeated misuse of a provider network provision;

(f) The small employer carrier elects to not renew all of its health benefit plans issued to small employers in Washington state. In such a case the carrier shall:

(i) Provide advance notice of its decision under this subsection (1)(f)(i) to the commissioner; and

(ii) Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected covered individual is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit plan by the carrier. Notice to the commissioner under this subsection (1)(f)(ii) shall be provided at least three working days prior to the notice to the affected small employers; or

(g) The commissioner finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the commissioner shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier that elects not to renew a health benefit plan under subsection (1)(f) of this section shall be prohibited from writing new business in the small employer market in Washington state for a period of five years from the date of notice to the commissioner.

(3) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in such service area."

"NEW SECTION. **Sec. 47.** GENERAL SMALL EMPLOYER CARRIER REQUIREMENTS. (1) A health benefit plan covering small employers shall comply with the following provisions:

(a) A small employer carrier shall file with the commissioner, in a form and manner prescribed by the commissioner, the basic health benefit plans to be used by the carrier. A health benefit plan filed pursuant to this subsection (1)(a) may be used by a small employer carrier beginning thirty days after it is filed unless the commissioner disapproves its use.

(b) A health benefit plan shall not deny, exclude, or limit benefits for a covered individual for losses incurred more than six months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than:

(i) A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the six months immediately preceding the effective date of coverage;

(ii) A condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; or

(iii) A pregnancy existing on the effective date of coverage.

(c) A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage that provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not less than thirty days prior to the effective date of the new coverage. This subsection (1)(c) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(d) A health benefit plan may exclude coverage for late enrollees for the greater of twelve months or for a twelve-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed twelve months from the date the individual enrolls for coverage under the health benefit plan.

(e)(i) Except as provided in (iv) of this subsection (1)(e), requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier.

(ii) A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(iii)(A) Except as provided in (iii)(B) of this subsection (1)(e), in applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who have qualifying existing coverage in determining whether the applicable percentage of participation is met.

(B) With respect to a small employer with ten or fewer eligible employees, a small employer carrier may consider employees or dependents who have coverage under another health benefit plan sponsored by such small employer in applying minimum participation requirements.

(iv) A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(f)(i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of the small employer and their dependents. A small employer carrier shall not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in (e) of this subsection.

(ii) A small employer carrier shall not modify a basic health benefit plan with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the basic health benefit plan.

(2)(a) Every small employer carrier shall, as a condition of transacting business in Washington state with small employers, actively offer to small employers at least a basic health benefit plan.

(b)(i) A small employer carrier shall issue at least a basic health benefit plan to any eligible small employer that applies to such a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter.

(ii) An allocating small employer carrier shall issue at least the basic health benefit plan or an approved minimum benefit plan to any eligible small employer that applies to such a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter, until the carrier's allotment of high-risk individuals has been met under section 48 of this act.

(c) A small employer is eligible under subsection (2)(b) of this section if it employed at least three unrelated eligible employees within Washington state on at least fifty percent of its working days during the preceding calendar quarter.

(d) For purposes of establishing continued small employer eligibility under this chapter, a small employer carrier may reassess the size of the covered employer on the anniversary date of the employer's policy. Coverage under this chapter may be discontinued if the small employer no longer meets the size requirements provided for in this chapter. However, if a small employer falls below the minimum size, coverage must be continued for a period of at least one year before the small employer carrier can discontinue coverage under this chapter, provided that the small employer continues to fall below the minimum group size requirements of this chapter.

(e) The provisions of this subsection shall be effective one hundred eighty days after the commissioner's approval of the basic health benefit plan developed under section 49 of this act, provided that if the small employer allocation program created under section 48 of this act is not yet in operation on such date, the provisions of this subsection shall be effective on the date that such program begins operation."

"NEW SECTION. **Sec. 48.** SMALL EMPLOYER ALLOCATION PROGRAM. (1) All small employer carriers issuing health benefit plans in this state on and after the effective date of this act shall be required to meet the requirements of this section as a condition of authority to transact business in Washington state.

(2) There is created a nonprofit entity to be known as the Washington small employer allocation program. All small employer carriers issuing health benefit plans in Washington state on and after the effective date of this act shall be allocating carriers in the program.

(3) The program shall operate subject to the supervision and control of the board of the Washington health insurance pool, as established by chapter 48.41 RCW.

(4) Within sixty days of the effective date of this act, each small employer carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived from health benefit plans issued to small employers in this state in the previous calendar year.

(5) Within one hundred eighty days after the appointment of the initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments thereto necessary or suitable, to assure the fair, reasonable, and equitable administration of the

program. The commissioner may, after notice and hearing, approve the plan of operation if the commissioner determines that it is required to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains or losses on an equitable and proportionate basis in accordance with the provisions of this section. The plan of operation shall become effective upon approval in writing by the commissioner.

(6) If the board fails to submit a suitable plan of operation within one hundred eighty days after its appointment, the commissioner shall, after notice and hearing, adopt a temporary plan of operation. The commissioner shall amend or rescind any plan adopted under this section at the time a plan of operation is submitted by the board and approved by the commissioner.

(7) The plan of operation shall:

(a) Establish procedures for handling and accounting of program assets and moneys and for an annual fiscal reporting to the commissioner;

(b) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(c) Establish procedures for assigning allotments of high-risk individuals and small employers among small employer carriers in accordance with the provisions of this chapter;

(d) Establish procedures for collecting assessments from all members subject to assessment to provide for administrative expenses incurred or estimated to be incurred for the period for which the assessment is made; and

(e) Provide for any additional matters necessary for the implementation and administration of the program.

(8) The program shall have the general powers and authority granted under the laws of Washington state to insurance companies, health care

service contractors, and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition thereto, the program shall have the specific authority to:

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

(b) Sue or be sued, including taking any legal actions necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any allocating carriers;

(c) Establish rules, conditions, and procedures pertaining to its functions under this chapter;

(d) Assess allocating carriers in accordance with the provisions of subsection (12) of this section, and to make interim assessment as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

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

(f) Borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets;

(g) Perform other functions necessary and proper to carry out its responsibilities under this chapter.

(9) The board shall establish procedures, as part of the plan of operation, for determining allotments of high-risk individuals and small employers among all allocating carriers. Such procedures shall be designed to assure a fair allocation of risks among allocating small employer carriers. The procedures shall include the following:

(a) A method by which the board shall estimate each year the total number of high-risk individuals in small employer groups that will be identified and used for determining carrier allotments under this subsection during the year. The board shall develop a uniform definition of a high-risk individual based on standardized medical underwriting criteria for purposes of this section.

(b) A method by which the program shall assign to each small employer carrier a target number of high-risk individuals. The target number for a small employer carrier shall bear the same proportional relationship to the total number of high-risk individuals estimated under (a) of this subsection as the small employer carrier’s annual net premiums for coverage of small employers bears to the annual net premiums of all small employer carriers for coverage of small employers. In the case of a small employer carrier with an established geographic services area, the board may adjust the target number of high-risk individuals to account for the carrier’s increased or decreased exposure resulting from the allocation.

(c) A procedure by which the program shall determine the number of high-risk eligible employees and dependents of each small employer that constitutes the carrier’s allotment of high-risk individuals and small employers.

(d) A procedure by which small employers that are identified as high risk may select an allocating carrier from a list in the program. The procedure shall provide for the small employer to be allocated to choose among allocating carriers unless, as a result of the addition of

the small employer, the carrier's target number determined under (b) of this subsection would be exceeded. A small employer that is rejected by the carrier that it initially selects shall make selections from a list of allocating carriers that have not yet met their allotments of high-risk individuals and small employers.

(e) A procedure by which the board shall determine, as for each calendar year, the extent to which the average claims costs incurred by a small employer carrier for providing coverage to high-risk individuals, whether allocated or identified in that year or any preceding year, is greater or less than the average claims cost incurred by small employer carriers for providing coverage to all high-risk individuals, whether allocated in that calendar year or any preceding year, that have been allocated or identified under the program.

(i) The procedure shall provide for the board to adjust the target number for a small employer carrier for the subsequent year if the average claims cost incurred by such carrier from providing coverage to high-risk individuals is either more or less, by at least the applicable percentage determined in (e)(ii) of this subsection, than the average claims cost for all high-risk individuals allocated under the program.

(ii) The procedure shall provide for the board to determine a percentage amount for the purpose of (e)(i) of this subsection. In determining such percentage, the board shall balance the following objectives:

(A) Achieving an equitable distribution among small employer carriers of the claims costs of high-risk individuals;

(B) Efficient administration of the program; and

(C) Providing incentive for small employer carriers to manage the care of high-risk individuals allotted under the program.

(10) The board shall periodically evaluate the program to assure equity in the distribution of allotted small employers. The board, subject to the approval of the commissioner, shall have the authority to make adjustments to the procedures established pursuant to this subsection to further the goal of equitable distribution of allocated small employers.

(11) A small employer carrier shall not be required to accept small employers that are not located within their established geographic service area or areas.

(12)(a) Following the close of each fiscal year, the administering carrier shall determine the program expenses of the administration. The net expense for the year shall be recouped by assessment on the allocating carriers. The administering carrier also shall determine the claims expense for allocated small employers for each small employer carrier for the basic health benefit plan, on an annual basis, using information collected from carriers under subsection (15) of this section.

(b) Assessments to cover the administrative expenses of the program shall be apportioned by the board among allocating carriers in proportion to their respective shares of the total premiums earned from health benefit plans issued to small employers in Washington state by all allocating carriers during the calendar year coinciding with or ending during the fiscal year of the program. Premiums earned by allocating carriers that are less than an amount determined by the board to justify the cost of assessment collection shall not be considered for purposes of determining assessments.

(c) Each allocating carrier’s assessment shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the allocating carrier with board.

(d) The plan of operation shall provide for the imposition of an interest penalty for late payment of assessments.

(e) An allocating carrier may seek from the commissioner a deferment from all or part of its assessment if payment of the assessment would place the allocating carrier in a financially impaired condition. The commissioner shall make such a determination and allow all or part of the assessment deferral. If all or part of an assessment against an allocating carrier is deferred, the amount deferred shall be assessed against the other allocating carriers in a manner set forth in this subsection. The allocating carrier receiving the deferment shall remain liable to the program for the amount deferred.

(13) Except as provided in subsection (11) of this section, allocating carriers shall accept application from all small employers until their allotments for high-risk individuals are met, as determined by the board pursuant to subsection (9) of this section. The allocating carrier shall offer all small employers a benefit plan that at least offers the benefits contained in the basic health benefit plan. An allocating carrier may also offer to small employers coverage that is more comprehensive than that required by this chapter.

(14) An allocating carrier shall not be required to provide coverage to small employers under this section for any period of time for which the commissioner determines that the participation in the program could place the small employer carrier in a financially impaired condition. In such instances, such small employer carriers will be prohibited from accepting application from any small employer until the commissioner determines that the carrier can accept small employers allocated from the program.

(15) Each allocating carrier shall file with the commissioner, in a form and manner to be prescribed by the commissioner, an annual

report. The report shall state the small employer carrier's net premium for new small employer coverage written in the previous twelve-month period. The report also shall state the number of small employers with high-risk individuals that meet the standard underwriting criteria for high-risk individuals, the claims expenses for these high-risk individuals, the names and number of the small employers that canceled or terminated coverage with it during the preceding calendar year, and the reasons for such cancellations or terminations, if known. The report shall be filed on or before March 1 for the preceding calendar year. A copy of the report shall be provided to the board.

(16) Neither the participation in the program, the establishment of procedures, nor any other joint or collective action required by this chapter shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any allocating carrier either jointly or separately.

(17) The program shall be exempt from any and all taxes.

(18) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to producers for the sale of basic health benefit plans. In establishing such standards, the board shall take into consideration: The need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensations currently used in the industry, and the overall costs of coverage to small employers selecting these plans."

"NEW SECTION. **Sec. 49.** HEALTH BENEFIT PLAN COMMITTEE. (1) The commissioner shall appoint a health benefit plan committee. The committee shall be composed of representatives from small employer

carriers, including insurance companies, health care service contractors, health maintenance organizations, other carriers, small employers, employees, health care providers, and producers.

(2) The committee shall recommend the form and level of coverage to be made available by small employer carriers under sections 47 and 48 of this act.

(3)(a) The committee shall recommend benefit levels, cost sharing levels, exclusions, and limitations for the basic health benefit plan. The committee shall also design a basic health benefit plan that contains benefit and cost sharing levels that are consistent with the basic method of operation and benefits of health maintenance organizations, including any restrictions imposed by federal law.

(b) The committee shall submit the health benefit plan described in (a) of this subsection to the commissioner for approval within one hundred eighty days after the appointment of the committee.

(c)(i) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plan to be used by the carrier. A health benefit plan filed pursuant to this subsection (3)(c)(i) may be used by a small employer carrier beginning thirty days after it is filed unless the commissioner disapproves its use.

(ii) The commissioner at any time may, after providing written notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic health benefit plan on the grounds that the plan does not meet the requirements of this subsection."

"NEW SECTION. **Sec. 50.** PERIODIC MARKET EVALUATION. (1) The board, in consultation with members of the committee, shall study and report at least every three years to the commissioner on the

effectiveness of this chapter. The report shall analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health insurance market place. The report shall address whether carriers and producers are fairly and actively marketing and issuing health benefit plans to small employers in fulfillment of the purposes of this chapter. The report may contain recommendations for market conduct or other regulatory standards or actions.

(2) The board shall commission an actuarial study, by an independent actuary approved by the commissioner, within the first three years of the operation of the program to evaluate and measure the relative risks being assumed by differing types of small employer carriers as a result of this chapter."

"NEW SECTION. **Sec. 51.** WAIVER OF CERTAIN STATE LAWS. No law requiring the coverage of a health care service or benefit, or requiring the reimbursement, utilization, or inclusion of a specific category of licensed health care practitioner, shall apply to a basic health benefit plan issued pursuant to this chapter."

"NEW SECTION. **Sec. 52.** ADMINISTRATIVE PROCEDURES. The commissioner may issue rules to implement this chapter."

"NEW SECTION. **Sec. 53.** STANDARDS TO ASSURE FAIR MARKETING. (1) An allocating small employer carrier that denies coverage to a small employer on the basis of standard medical underwriting criteria established by the board of the program as applied to the small employer’s employees or dependents shall provide notice to the small

employer, in a form and manner prescribed by the commissioner, of the potential availability of coverage through the allocation program.

(2) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for placing small employers with the small employer carrier through the program.

(3) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with a producer because the producer has placed small employers with the small employer carrier.

(4) No small employer carrier or producer shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee’s employment.

(5) Denial by an allocating small employer carrier of an application for coverage from a small employer shall be consistent with the provisions of section 48 of this act, shall be in writing, and shall state the reason or reasons for the denial.

(6) The commissioner may adopt by rule additional standards to provide for the availability of health benefit plans to small employers through the program.

(7)(a) A violation of this section by a small employer carrier or producer shall be an unfair trade practice under chapter 48.30 RCW.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or the other services related to the offering of health benefit plans to small employers in Washington state, the third-party administrator shall be subject to this section as if it were a small employer carrier."

"NEW SECTION. **Sec. 54.** APPLICATION OF CHAPTER TO CHAPTERS 48.20, 48.21, AND 48.44 RCW. This chapter applies to carriers regulated under chapters 48.21, 48.44, and 48.46 RCW."

"PART XI - MISCELLANEOUS"

"**Sec. 55.** RCW 70.42.080 and 1989 c 386 s 9 are each amended to read as follows:

A test site shall have a designated test site supervisor who shall ((~~meet the~~)) hold an appropriate health care professional license granted by the state of Washington or certification granted by a nationally recognized clinical laboratory science certification organization. Test site supervisor qualifications shall be determined by the department in rule. The designated test site supervisor shall be responsible for the testing functions of the test site."

"NEW SECTION. **Sec. 56.** The legislative budget committee shall conduct a study, either directly or by contract, to determine the desirability and feasibility of consolidating the following programs, services, and funding sources into any scheme for universal access to health care and cost containment that may be adopted by the legislature:

(1) Medical services of the workers' compensation program of the department of labor and industries;

(2) Developmental disabilities, mental health, and long-term care programs of the department of social and health services;

(3) State and federal veterans' health services; and

(4) Civilian health and medical program of the uniformed services (CHAMPUS) of the federal department of defense and other federal agencies.

The report shall be made to the governor and the appropriate committees of the legislature by July 1, 1993."

"NEW SECTION. **Sec. 57.** EFFECTIVE DATE. Sections 41 through 54 of this act shall take effect January 1, 1993."

"NEW SECTION. **Sec. 58.** Sections 41 through 54 of this act shall constitute a new chapter in Title 48 RCW."

"NEW SECTION. **Sec. 59.** CODIFICATION INSTRUCTIONS. Sections 10 and 38 of this act are each added to chapter 70.47 RCW."

"NEW SECTION. **Sec. 60.** CODIFICATION INSTRUCTIONS. Sections 14 and 15 of this act shall constitute a new chapter in Title 18 RCW."

"NEW SECTION. **Sec. 61.** CODIFICATION INSTRUCTIONS. Sections 17 through 27 of this act are each added to chapter 7.70 RCW."

"NEW SECTION. **Sec. 62.** CAPTIONS NOT LAW. Captions as used in this act constitute no part of the law."

"NEW SECTION. **Sec. 63.** SEVERABILITY. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected."

"NEW SECTION. **Sec. 64.** NULL AND VOID PROVISIONS. If specific funding for the purpose of sections 11 through 15 of this act, referencing this act by bill number, is not provided by June 30, 1992,

in the omnibus appropriations act, those sections of this act shall be null and void."

"NEW SECTION. **Sec. 65.** NULL AND VOID PROVISIONS. If specific funding for the purpose of sections 41 through 54 of this act, referencing this act by bill number, is not provided by June 30, 1992, in the omnibus appropriations act, those sections of this act shall be null and void."

SB 6089 - S COMM AMD
By Committee on Ways & Means

ADOPTED 3/5/92

On page 1, line 1 of the title, after "care;" strike the remainder of the title and insert "amending RCW 70.47.010, 70.47.020, 70.47.080, 70.47.120, 70.170.010, 70.170.030, 70.170.040, 7.70.070, 19.68.010, 48.14.022, and 70.42.080; reenacting and amending RCW 70.47.030 and 70.47.060; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.21 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.84 RCW; adding new sections to chapter 41.05 RCW; adding a new section to chapter 43.20A RCW; adding a new section to Title 51 RCW; adding new sections to chapter 70.47 RCW; adding new sections to chapter 7.70 RCW; adding a new chapter to Title 48 RCW; adding a new chapter to Title 18 RCW; creating new sections; repealing RCW 43.131.355 and 43.131.356; prescribing penalties; and providing an effective date."