1046-S.E AAS 4/14/95

ESHB 1046 - S AMD - 386
By Senators Quigley, Deccio, Owen and Moyer

ADOPTED AS AMENDED 4/14/95

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** A new section is added to chapter 70.47 RCW to read as follows:

BASIC HEALTH PLAN--EXPANDED ENROLLMENT. (1) The legislature finds that the basic health plan has been an effective program in providing health coverage for uninsured residents. Further, since 1993, substantial amounts of public funds have been allocated for subsidized basic health plan enrollment.

(2) It is the intent of the legislature that the basic health plan enrollment be expanded expeditiously, consistent with funds available in the health services account, with the goal of two hundred thousand adult subsidized basic health plan enrollees and one hundred thirty thousand children covered through expanded medical assistance services by June 30, 1997, with the priority of providing needed health services to children in conjunction with other public programs.

(3) Effective January 1, 1996, basic health plan enrollees whose income is less than one hundred twenty-five percent of the federal poverty level shall pay at least a ten-dollar premium share.

(4) No later than July 1, 1996, the administrator shall implement procedures whereby hospitals licensed under chapters 70.41 and 71.12 RCW, health carrier, rural health care facilities regulated under chapter 70.175 RCW, and community and migrant health centers funded under RCW 41.05.220, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process.

(5) No later than July 1, 1996, the administrator shall implement procedures whereby health insurance agents and brokers, licensed under

chapter 48.17 RCW, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. Brokers and agents shall be entitled to receive a commission for each individual sale of the basic health plan to anyone not at anytime previously signed up and a commission for each group sale of the basic health plan. No commission shall be provided upon a renewal. Commissions shall be determined based on the estimated annual cost of the basic health plan, however, commissions shall not result in a reduction in the premium amount paid to health carriers. For purposes of this section "health carrier" is as defined in section 4 of this act. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process.

NEW SECTION. **Sec. 2.** HEALTH CARE SAVINGS ACCOUNTS. (1) This chapter shall be known as the health care savings account act.

(2) The legislature recognizes that the costs of health care are increasing rapidly and most individuals are removed from participating in the purchase of their health care.

As a result, it becomes critical to encourage and support solutions to alleviate the demand for diminishing state resources. In response to these increasing costs in health care spending, the legislature intends to clarify that health care savings accounts may be offered as health benefit options to all residents as incentives to reduce unnecessary health services utilization, administration, and paperwork, and to encourage individuals to be in charge of and participate directly in their use of service and health care spending. To alleviate the possible impoverishment of residents requiring long-term care, health care savings accounts may promote savings for long-term care and provide incentives for individuals to protect themselves from financial hardship due to a long-term health care need.

(3) Health care savings accounts are authorized in Washington state as options to employers and residents.

NEW SECTION. **Sec. 3.** HEALTH CARE SAVINGS ACCOUNTS--REQUEST FOR TAX EXEMPTION. The governor and responsible agencies shall:

(1) Request that the United States congress amend the internal revenue code to treat premiums and contributions to health benefits plans, such as health care savings account programs, basic health plans, conventional and standard health plans offered through a health carrier, by employers, self-employed persons, and individuals, as fully excluded employer expenses and deductible from individual adjusted gross income for federal tax purposes.

(2) Request that the United States congress amend the internal revenue code to exempt from federal income tax interest that accrues in health care savings accounts until such money is withdrawn for expenditures other than eligible health expenses as defined in law.

(3) If all federal statute or regulatory waivers necessary to fully implement this chapter have not been obtained by the effective date of this section, this chapter shall remain in effect.

NEW SECTION. **Sec. 4.** DEFINITIONS. Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

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

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

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

shall not be considered eligible employees for purposes of minimum participation requirements of this act.

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

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

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

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

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

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

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

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

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage.

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

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

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

(13) "Small employer" means any person, firm, corporation, partnership, association, political subdivision except school districts, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of

determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate Internal Revenue Service form 1040, Schedule C or F, for the previous taxable year.

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

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

NEW SECTION. **Sec. 5.** INSURANCE REFORM--PORTABILITY. (1) Every health carrier shall waive any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different health plan at any time during the three-month period immediately preceding the date of application for the new health plan if such person was continuously covered under the immediately preceding health plan. If the person was continuously covered for at least three months under the immediately preceding health plan, the carrier may not impose a waiting period for coverage of preexisting conditions. If the person was continuously covered for less than three months under the immediately preceding health plan, the carrier must credit any waiting period under the immediately preceding health plan toward the new health plan. For the purposes of this subsection, a preceding health plan includes an employer provided self-funded health plan.

(2) Subject to the provisions of subsection (1) of this section, nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its existing health plans. In

addition, nothing in this section requires a carrier to waive benefit limitations not related to an individual or group's preexisting conditions or health history.

NEW SECTION. **Sec. 6.** INSURANCE REFORM--PREEXISTING CONDITIONS. (1) No carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that a carrier may impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within three months before the effective date of coverage.

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

NEW SECTION. **Sec. 7.** INSURANCE REFORM--GUARANTEED ISSUE. (1) All health carriers shall accept for enrollment any state resident within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The insurance commissioner may grant a temporary exemption from this subsection, if, upon application by a health carrier the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

(2) Except as provided in subsection (5) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been

terminated for other than nonpayment of premium. In the case of group plans, the carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

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

(a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

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

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

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

Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

(2) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals.

NEW SECTION. **Sec. 9.** WASHINGTON HEALTH CARE POLICY BOARD. (1) There is hereby created the Washington health care policy board. The board shall consist of: (a) Five members appointed by the governor; (b) two members of the senate appointed by the president of the senate, one of whom shall be a member of the minority party; and (c) two members of the house of representatives appointed by the speaker of the house of representatives, one of whom shall be a member of the minority party. One member of the board shall be designated by the governor as chair and shall serve at the pleasure of the governor. All legislative members shall be appointed before the close of each regular or special session during an odd-numbered year.

(2) Of the members appointed by the governor, two shall be appointed to two-year terms and two shall be appointed to three-year terms. Thereafter, members shall be appointed to three-year terms. The chair shall serve at the pleasure of the governor. Vacancies shall be filled by appointment for the remainder of the unexpired term of the position being vacated. A majority of the voting members shall constitute a quorum.

(3) Members of the board appointed by the governor shall occupy their positions on a full-time basis and are exempt from the provisions of chapter 41.06 RCW. They shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040.

NEW SECTION. **Sec. 10.** CHAIR--POWERS AND DUTIES. The chair shall be the chief administrative officer and the appointing authority of the board. The chair shall have the authority to employ personnel of the board in accordance with chapter 41.06 RCW and prescribe their duties. The chair may employ up to eight personnel exempt from the provisions of chapter 41.06 RCW. The chair shall also have the following powers and duties:

(1) Enter into contracts on behalf of the board;

(2) Accept and expend donations, grants, and other funds received by the board;

(3) Appoint advisory committees and undertake studies, research, and analysis necessary to support activities of the board.

NEW SECTION. **Sec. 11.** BOARD--POWERS AND DUTIES. The board shall have the following powers and duties:

(1) Periodically make recommendations to the appropriate committees of the legislature and the governor on issues including, but not limited to the following:

(a) The scope, financing, and delivery of health care benefit plans including access for both the insured and uninsured population;

(b) Long-term care services including the finance and delivery of such services in conjunction with the basic health plan by 1999;

(c) The use of health care savings accounts including their impact on the health of participants and the cost of health insurance;

(d) Rural health care needs;

(e) Whether Washington is experiencing an increase in immigration as a result of health insurance reforms and the availability of subsidized and unsubsidized health care benefits;

(f) The status of medical education and make recommendations regarding steps possible to encourage adequate availability of health care professionals to meet the needs of the state’s populations with particular attention to rural areas;

(g) The implementation of community rating and its impacts on the marketplace including costs and access;

(h) The status of quality improvement programs in both the public and private sectors;

(i) Models for billing and claims processing forms, ensuring that these procedures minimize administrative burdens on health care providers, facilities, carriers, and consumers. These standards shall also apply to state-purchased health services where appropriate;

(j) Guidelines to health carriers for utilization management and review, provider selection and termination policies, and coordination of benefits and premiums; and

(k) Study the feasibility of including long-term care services in a medicare supplemental insurance policy offered according to RCW 41.05.197;

(2) Review rules prepared by the insurance commissioner, health care authority, department of social and health services, department of labor and industries, and department of health, and make recommendations where appropriate to facilitate consistency with the goals of health reform;

(3) Make recommendations on a system for managing health care services to children with special needs and report to the governor and the legislature on their findings by January 1, 1997;

(4) Conduct a comparative analysis of individual and group insurance markets addressing: Relative costs; utilization rates; adverse selection; and specific impacts upon small businesses and individuals. The analysis shall address, also, the necessity and feasibility of establishing explicit related policies, to include, but not be limited to, establishing the maximum allowable individual premium rate as a percentage of the small group premium rate. The board shall submit an interim report on its findings to the governor and appropriate committees of the legislature by December 15, 1995, and a final report on December 15, 1996;

(5) Develop sample enrollee satisfaction surveys that may be used by health carriers.

NEW SECTION. **Sec. 12.** STUDY. In January 1999 the legislative budget committee shall commence a study of the necessity of the existence of the board and report its recommendations to the appropriate committees of the legislature by December 1, 1999.

NEW SECTION. **Sec. 13.** A new section is added to chapter 48.20 RCW to read as follows:

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

payer. Both rates shall be subject to the requirements of this subsection.

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

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

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

(i) Changes to the family composition;

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

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

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in section 5 of this act.

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

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

Sec. 14. RCW 48.21.045 and 1990 c 187 s 2 are each amended to read as follows:

((~~A basic group disability insurance policy may be offered to employers of fewer than twenty-five employees. Such a basic group disability insurance policy~~)) (1)(a) An insurer offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in section 5 of this act.

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

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

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

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

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

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

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

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

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

(7) As used in this section, "health benefit plan," "small employer," "basic health plan," "adjusted community rate," and "wellness activities" mean the same as defined in section 4 of this act.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.44 RCW to read as follows:

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in section 5 of this act.

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

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

Sec. 16. RCW 48.44.023 and 1990 c 187 s 3 are each amended to read as follows:

((~~A basic health care service contract may be offered to employers of fewer than twenty-five employees. Such a basic health care service contract~~)) (1)(a) A health care services contractor offering any health benefit plan to a small employer shall offer and actively market to the small employer a health benefit plan providing benefits identical to the schedule of covered health services that are required to be delivered to an individual enrolled in the basic health plan. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan,

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in section 5 of this act.

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 17.** A new section is added to chapter 48.46 RCW to read as follows:

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

(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.26.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if the health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan.

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in section 5 of this act.

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

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

Sec. 18. RCW 48.46.066 and 1990 c 187 s 4 are each amended to read as follows:

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

(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355,

48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530 if: (i) The health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan; or (ii) the health benefit plan is offered to employers with not more than twenty-five employees.

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

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

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

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

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

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

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

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

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

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

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

(h) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in section 5 of this act.

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

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

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

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

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

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

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or

dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

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

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

NEW SECTION. **Sec. 19.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The identity of a whistleblower who complains, in good faith, to the department of health about the improper quality of care by a health care provider, or in a health care facility, as defined in RCW 43.72.010, shall remain confidential. The provisions of RCW 4.24.500 through 4.24.520, providing certain protections to persons who communicate to government agencies, shall apply to complaints filed under this section. The identity of the whistleblower shall remain confidential unless the department determines that the complaint was not made in good faith. An employee who is a whistleblower, as defined in this section, and who as a result of being a whistleblower has been subjected to workplace reprisal or retaliatory action has the remedies provided under chapter 49.60 RCW.

(2)(a) "Improper quality of care" means any practice, procedure, action, or failure to act that violates any state law or rule of the applicable state health licensing authority under Title 18 or chapters 70.41, 70.96A, 70.127, 70.175, 71.05, 71.12, and 71.24 RCW, and enforced by the department of health. Each health disciplinary authority as defined in RCW 18.130.040 may, with consultation and interdisciplinary coordination provided by the state department of health, adopt rules defining accepted standards of practice for their

profession that shall further define improper quality of care. Improper quality of care shall not include good faith personnel actions related to employee performance or actions taken according to established terms and conditions of employment.

(b) "Reprisal or retaliatory action" means but is not limited to: Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct pursuant to Title 18 RCW; letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion; suspension; dismissal; denial of employment; and a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower.

(c) "Whistleblower" means a consumer, employee, or health care professional who in good faith reports alleged quality of care concerns to the department of health.

(3) Nothing in this section prohibits a health care facility from making any decision exercising its authority to terminate, suspend, or discipline an employee who engages in workplace reprisal or retaliatory action against a whistleblower.

(4) The department shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under Title 18 RCW for health professionals or health care facilities.

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

Each health carrier as defined under section 4 of this act shall file with the commissioner its procedures for review and adjudication of complaints initiated by covered persons or health care providers. Procedures filed under this section shall provide a fair review for consideration of complaints. Every health carrier shall provide reasonable means whereby any person aggrieved by actions of the health carrier may be heard in person or by their authorized representative on their written request for review. If the health carrier fails to grant or reject such request within thirty days after it is made, the complaining person may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted

pursuant to mediation rules similar to those of the American arbitration association, the center for public resources, the judicial arbitration and mediation service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

NEW SECTION. **Sec. 21.** The health care authority, the office of financial management, and the department of social and health services shall together monitor the enrollee level in the basic health plan and the medicaid caseload of children funded from the health services account. The office of financial management shall adjust the funding levels by interagency reimbursement of funds between the basic health plan and medicaid and adjust the funding levels between the health care authority and the medical assistance administration of the department of social and health services to maximize combined enrollment.

NEW SECTION. **Sec. 22.** A new section is added to chapter 48.21 RCW to read as follows:

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

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

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in section 4 of this act.

NEW SECTION. **Sec. 23.** A new section is added to chapter 48.44 RCW to read as follows:

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

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care shall not be considered small employers and such plans shall not be subject to the provisions of RCW 48.44.023(5).

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in section 4 of this act.

NEW SECTION. **Sec. 24.** A new section is added to chapter 48.46 RCW to read as follows:

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

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

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in section 4 of this act.

NEW SECTION. **Sec. 25.** (1) The legislature recognizes that every individual possesses a fundamental right to exercise their religious beliefs and conscience. The legislature further recognizes that in developing public policy, conflicting religious and moral beliefs must be respected. Therefore, while recognizing the right of conscientious objection to participating in specific health services, the state shall also recognize the right of individuals enrolled with plans containing the basic health plan services to receive the full range of services covered under the plan.

(2)(a) No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

(b) The provisions of this section are not intended to result in an enrollee being denied timely access to any service included in the basic health plan services. Each health carrier shall:

(i) Provide written notice to enrollees, upon enrollment with the plan, listing services that the carrier refuses to cover for reason of conscience or religion;

(ii) Provide written information describing how an enrollee may directly access services in an expeditious manner; and

(iii) Ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b)(ii) of this subsection.

(c) The insurance commissioner shall establish by rule a mechanism or mechanisms to recognize the right to exercise conscience while ensuring enrollees timely access to services and to assure prompt payment to service providers.

(3)(a) No individual or organization with a religious or moral tenet opposed to a specific service may be required to purchase coverage for that service or services if they object to doing so for reason of conscience or religion.

(b) The provisions of this section shall not result in an enrollee being denied coverage of, and timely access to, any service or services excluded from their benefits package as a result of their employer's or another individual's exercise of the conscience clause in (a) of this subsection.

(c) The insurance commissioner shall define by rule the process through which health carriers may offer the basic health plan services to individuals and organizations identified in (a) and (b) of this subsection in accordance with the provisions of subsection (2)(c) of this section.

(4) Nothing in this section requires a health carrier, health care facility, or health care provider to provide any health care services without appropriate payment of premium or fee.

NEW SECTION. **Sec. 26.** The department of social and health services, in consultation with the health care authority, the office of financial management, and other appropriate state agencies, shall seek necessary federal waivers and state law changes to the medical assistance program of the department to achieve greater coordination in financing, purchasing, and delivering health services to low-income residents of Washington state in a cost-effective manner, and to expand access to care for these low-income residents. Such waivers shall include any waiver needed to require that point-of-service cost-sharing, based on recipient household income, be applied to medical assistance recipients. In negotiating the waiver, consideration shall be given to the degree to which benefits in addition to the minimum list of services should be offered to medical assistance recipients.

NEW SECTION. **Sec. 27.** REPEALERS. The following acts or parts of acts are each repealed:

(1) RCW 18.130.320 and 1993 c 492 s 408;

(2) RCW 18.130.330 and 1994 c 102 s 1 & 1993 c 492 s 412;
(3) RCW 43.72.005 and 1993 c 492 s 401;
(4) RCW 43.72.010 and 1994 c 4 s 1, 1993 c 494 s 1, & 1993 c 492 s 402;
(5) RCW 43.72.020 and 1994 c 154 s 311 & 1993 c 492 s 403;
(6) RCW 43.72.030 and 1993 c 492 s 405;
(7) RCW 43.72.040 and 1994 c 4 s 3, 1993 c 494 s 2, & 1993 c 492 s 406;
(8) RCW 43.72.050 and 1993 c 492 s 407;
(9) RCW 43.72.060 and 1994 c 4 s 2 & 1993 c 492 s 404;
(10) RCW 43.72.070 and 1993 c 492 s 409;
(11) RCW 43.72.080 and 1993 c 492 s 425;
(12) RCW 43.72.090 and 1993 c 492 s 427;
(13) RCW 43.72.100 and 1993 c 492 s 428;
(14) RCW 43.72.110 and 1993 c 492 s 429;
(15) RCW 43.72.120 and 1993 c 492 s 430;
(16) RCW 43.72.130 and 1993 c 492 s 449;
(17) RCW 43.72.140 and 1993 c 492 s 450;
(18) RCW 43.72.150 and 1993 c 492 s 451;
(19) RCW 43.72.160 and 1993 c 492 s 452;
(20) RCW 43.72.170 and 1993 c 492 s 453;
(21) RCW 43.72.180 and 1993 c 492 s 454;
(22) RCW 43.72.190 and 1993 c 492 s 455;
(23) RCW 43.72.210 and 1993 c 492 s 463;
(24) RCW 43.72.220 and 1993 c 494 s 3 & 1993 c 492 s 464;
(25) RCW 43.72.225 and 1994 c 4 s 4;
(26) RCW 43.72.230 and 1993 c 492 s 465;
(27) RCW 43.72.240 and 1993 c 494 s 4 & 1993 c 492 s 466;
(28) RCW 43.72.300 and 1993 c 492 s 447;
(29) RCW 43.72.310 and 1993 c 492 s 448;
(30) RCW 43.72.800 and 1993 c 492 s 457;
(31) RCW 43.72.810 and 1993 c 492 s 474;
(32) RCW 43.72.820 and 1993 c 492 s 475;
(33) RCW 43.72.830 and 1993 c 492 s 476;
(34) RCW 43.72.840 and 1993 c 492 s 478;
(35) RCW 43.72.870 and 1993 c 494 s 5;
(36) RCW 48.01.200 and 1993 c 492 s 294;
(37) RCW 48.43.010 and 1993 c 492 s 432;
(38) RCW 48.43.020 and 1993 c 492 s 433;

(39) RCW 48.43.030 and 1993 c 492 s 434;
(40) RCW 48.43.040 and 1993 c 492 s 435;
(41) RCW 48.43.050 and 1993 c 492 s 436;
(42) RCW 48.43.060 and 1993 c 492 s 437;
(43) RCW 48.43.070 and 1993 c 492 s 438;
(44) RCW 48.43.080 and 1993 c 492 s 439;
(45) RCW 48.43.090 and 1993 c 492 s 440;
(46) RCW 48.43.100 and 1993 c 492 s 441;
(47) RCW 48.43.110 and 1993 c 492 s 442;
(48) RCW 48.43.120 and 1993 c 492 s 443;
(49) RCW 48.43.130 and 1993 c 492 s 444;
(50) RCW 48.43.140 and 1993 c 492 s 445;
(51) RCW 48.43.150 and 1993 c 492 s 446;
(52) RCW 48.43.160 and 1993 c 492 s 426;
(53) RCW 48.43.170 and 1993 c 492 s 431;
(54) RCW 48.01.210 and 1993 c 462 s 51;
(55) RCW 48.20.540 and 1993 c 492 s 283;
(56) RCW 48.21.340 and 1993 c 492 s 284;
(57) RCW 48.44.480 and 1993 c 492 s 285;
(58) RCW 48.46.550 and 1993 c 492 s 286;
(59) RCW 70.170.100 and 1993 c 492 s 259, 1990 c 269 s 12, & 1989 1st ex.s. c 9 s 510;
(60) RCW 70.170.110 and 1993 c 492 s 260 & 1989 1st ex.s. c 9 s 511;
(61) RCW 70.170.120 and 1993 c 492 s 261;
(62) RCW 70.170.130 and 1993 c 492 s 262;
(63) RCW 70.170.140 and 1993 c 492 s 263;
(64) RCW 48.44.490 and 1993 c 492 s 288;
(65) RCW 48.46.560 and 1993 c 492 s 289; and
(66) RCW 43.72.200 and 1993 c 492 s 456.

NEW SECTION. **Sec. 28.** CODIFICATION DIRECTION. (1) Sections 2 and 3 of this act shall constitute a new chapter in Title 48 RCW.

(2) Sections 4 through 7 and 25 of this act are each added to chapter 48.43 RCW.

(3) Sections 9 through 12 of this act shall constitute a new chapter in Title 43 RCW.

NEW SECTION. **Sec. 29.** CAPTIONS NOT LAW. Captions as used in this act constitute no part of the law.

NEW SECTION. **Sec. 30.** EFFECTIVE DATE. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1995, except that sections 13 through 18 of this act shall take effect January 1, 1996.

NEW SECTION. **Sec. 31.** SAVINGS CLAUSE. This act shall not be construed as affecting any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule or order adopted under those sections, nor as affecting any proceeding instituted under those sections.

NEW SECTION. **Sec. 32.** SEVERABILITY CLAUSE. 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."

ESHB 1046 - S AMD - 386
By Senators Quigley, Deccio, Owen and Moyer

ADOPTED 4/14/95

On page 1, line 1 of the title, after "improvement;" strike the remainder of the title and insert "amending RCW 48.21.045, 48.44.023, and 48.46.066; adding a new section to chapter 70.47 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 48.20 RCW; adding new sections to chapter 48.44 RCW; adding new sections to chapter 48.46 RCW; adding a new section to chapter 43.70 RCW; adding a new section to chapter 48.21 RCW; adding a new chapter to Title 48 RCW; adding a new chapter to Title 43 RCW; creating new sections; repealing RCW 18.130.320, 18.130.330, 43.72.005, 43.72.010, 43.72.020, 43.72.030, 43.72.040, 43.72.050, 43.72.060, 43.72.070, 43.72.080, 43.72.090, 43.72.100, 43.72.110, 43.72.120, 43.72.130, 43.72.140, 43.72.150, 43.72.160, 43.72.170, 43.72.180, 43.72.190, 43.72.210, 43.72.220, 43.72.225, 43.72.230, 43.72.240, 43.72.300, 43.72.310, 43.72.800, 43.72.810, 43.72.820, 43.72.830, 43.72.840, 43.72.870, 48.01.200, 48.43.010, 48.43.020, 48.43.030, 48.43.040, 48.43.050, 48.43.060,

48.43.070, 48.43.080, 48.43.090, 48.43.100, 48.43.110, 48.43.120, 48.43.130, 70.170.140, 48.43.140, 48.43.150, 48.43.160, 48.43.170, 48.01.210, 48.20.540, 48.21.340, 48.44.480, 48.46.550, 70.170.100, 70.170.110, 70.170.120, 70.170.130, 70.170.140, 48.44.490, 48.46.560, and 43.72.200; providing effective dates; and declaring an emergency."

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