H-3408.3

HOUSE BILL 2360

State of Washington 56th Legislature 2000 Regular Session

By Representatives Parlette, Buck, Pflug, D. Sommers, Mulliken, Schindler, G. Chandler and McMorris

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

AN ACT Relating to individual health insurance coverage; amending RCW 48.04.010, 48.20.028, 48.41.030, 48.41.060, 48.41.100, 48.41.110, 48.41.120, 48.41.200, 48.43.015, 48.43.025, 48.43.035, 48.44.020, 48.18.110, 48.44.022, 48.44.130, 48.46.060, 48.46.064, 48.46.300, 70.47.010, 70.47.020, and 70.47.100; reenacting and amending RCW 48.43.005 and 70.47.060; adding a new section to chapter 48.41 RCW; adding new sections to chapter 48.43 RCW; adding new sections to chapter 48.46 RCW; adding a new section to chapter 48.20 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.01 RCW; repealing RCW 48.41.180; and providing an effective date.

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

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

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

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

(b) Upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if

such failure is deemed an act under any provision of this code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing.

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

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

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

(5) A licensee under Title 48 RCW may request that a hearing authorized under this section be presided over by an administrative law judge assigned under chapter 34.12 RCW.

(6) Any hearing held relating to section 19, 21, or 25 of this act shall be presided over by an administrative law judge assigned under chapter 34.12 RCW. If the decision of the administrative law judge is appealed to superior court, the court shall order the party that does not prevail to pay pertinent court costs and reasonable attorneys' fees as is equitable and the court deems appropriate.

Sec. 2. RCW 48.20.028 and 1997 c 231 s 207 are each amended to read as follows:

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

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 3. RCW 48.41.030 and 1997 c 337 s 6 are each amended to read as follows:

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

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

other than twelve months as may be required for orderly management and accounting of the pool.

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

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

(4) "Commissioner" means the insurance commissioner.

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

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

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

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

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

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

((~~(10)~~)) (11) "Health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under this pool, have access to hospital and medical benefits or reimbursement including any group or individual disability insurance policy; health care service contract; health maintenance agreement; uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not

involving insurance or not governed by Title 48 RCW; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. This term includes coverage through "health coverage" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health coverage" in subsection ((~~(9)~~)) (10) of this section.

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

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

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

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

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

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

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

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

Sec. 4. RCW 48.41.060 and 1997 c 337 s 5 are each amended to read as follows:

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

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

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

~~(3)~~)) shall:

(a) Select a standard health questionnaire for use by pool administrators and health carriers under section 13 of this act. The questionnaire selected must have a valid history in another state of providing an objective evaluation of the health status of individuals applying for health insurance coverage. The questionnaire shall be applied uniformly by the pool administrator and carriers when determining access to the pool or individual insurance coverage and in no case shall the questionnaire result in more than eight percent of applicants for individual insurance coverage or eight percent of all persons enrolled in individual insurance coverage being denied coverage by any health carrier. The questionnaire must provide for an objective evaluation of an individual's health status by assigning a discrete measure, such as a system of point scoring to each individual. The questionnaire must not contain any questions related to pregnancy, and pregnancy shall not be a basis for coverage by the pool;

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

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

Notwithstanding chapter 34.05 RCW nothing in this section shall be considered a rule;

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

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

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

((~~(6)~~)) (g) Set a reasonable fee to be paid to an insurance agent licensed in Washington state for submitting an acceptable application for enrollment in the pool.

(2) In addition thereto, the board may:

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

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

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

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

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

(1) Any individual person who is a resident of this state is eligible for pool coverage ((~~upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on health insurance, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one member within six months of the date of application. Evidence of rejection may be waived in accordance with rules adopted by the board~~)) upon the pool receiving written evidence of a carrier's decision not to accept him or her for enrollment in an individual health benefit plan based upon the results of the standardized health questionnaire designated by the board and administered by health carriers under section 13 of this act.

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

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

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

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

(d) Any person who does not qualify for pool coverage based upon the results of the standardized health questionnaire.

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

Sec. 6. RCW 48.41.110 and 1997 c 231 s 213 are each amended to read as follows:

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

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

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

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

care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

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

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

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

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

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

(p) Hospice services;

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

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

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

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

((~~(5)~~)) (6) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it ((~~may~~)) shall impose a ((~~three-month~~)) six-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within ((~~three~~)) six months before the effective date of coverage. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be provided as required by section 12 of this act.

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 8.** A new section is added to chapter 48.41 RCW to read as follows:

The board shall design and offer a care management plan of coverage with the following components:

(1) Services similar to those contained in RCW 48.41.110(3) shall be covered.

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

(3) Enrollee cost-sharing that may include but not be limited to point-of-service cost-sharing for covered services and deductibles in amounts to be determined by the board. The board shall include an annual maximum out-of-pocket payment protection in the plan.

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

Sec. 9. RCW 48.41.200 and 1997 c 231 s 214 are each amended to read as follows:

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

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

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

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

(3) In no event shall the rate for any person be less than the standard risk rate calculated under subsection (1) of this section.

Sec. 10. RCW 48.43.005 and 1997 c 231 s 202 and 1997 c 55 s 1 are each reenacted and amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

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

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

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

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

((~~(6)~~)) (7) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(7)~~)) (8) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

((~~(8)~~)) (9) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

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

((~~(10)~~)) (11) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

((~~(11)~~)) (12) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

((~~(12)~~)) (13) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

((~~(13)~~)) (14) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the

covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

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

((~~(15)~~)) (16) "Health care provider" or "provider" means:

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

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

((~~(16)~~)) (17) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

((~~(17)~~)) (18) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

((~~(18)~~)) (19) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

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

((~~(19)~~)) (20) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

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

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

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

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

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

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

(26) "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.

Sec. 11. RCW 48.43.015 and 1995 c 265 s 5 are each amended to read as follows:

(1) For group contracts as defined in chapter 48.44 RCW, 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~~)) twelve-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~~)) twelve 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~~)) twelve 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 subsections (1) and (3) of this section, nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its existing health plans. In addition, nothing in this section requires a carrier to waive benefit limitations not related to an individual or group's preexisting conditions or health history.

(3) A health carrier shall credit any preexisting condition waiting period in its individual plans for a person who was enrolled in a group health benefit plan, or an individual health benefit plan other than a catastrophic plan, at any time during the sixty-three day period immediately preceding the date of application for the new health plan. The carrier must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer provided self-funded health plan.

NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43 RCW to read as follows:

(1) No carrier may reject an individual for individual health plan coverage based upon preexisting conditions of the individual except as provided in section 13 of this act.

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

(3) For individual coverage originally issued on or after the effective date of this section, preexisting condition waiting periods imposed upon a person enrolling in individual coverage shall be no more restrictive than twelve months for a preexisting condition for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months prior to the effective date of coverage.

NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43 RCW to read as follows:

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

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

(b) If a person is applying for individual coverage:

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

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

(iii) Application for coverage under that carrier's provider network individual coverage is made within ninety days of his or her

provider leaving the previous carrier's provider network; then completion of the standard health questionnaire shall not be a condition of coverage.

(2)(a) If, based upon the results of the standard health questionnaire, the person qualifies to apply for the Washington state health insurance pool, the carrier may decide not to accept the person's application for enrollment in its individual health plan.

(b) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the person's application for enrollment to the applicant. The notice to the applicant shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, shall include information about the Washington state health insurance pool, an application for such coverage, and information that the applicant's licensed insurance agent can submit an application for the person to the pool. In the event a licensed insurance agent submits an application to the pool the agent shall be entitled to a reasonable fee as determined by the board as provided by RCW 48.41.060.

(3) If, based upon the results of the standardized health questionnaire, the person does not qualify for coverage under the Washington state health insurance pool, the carrier shall accept the person for enrollment if he or she resides within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, geographic location, employment status, socioeconomic status, other condition or situation, or the provisions of RCW 49.60.174(2). The commissioner may grant a temporary exemption from this subsection if, upon application by a health carrier, the commissioner finds that the clinical, financial, or administrative capacity to serve existing enrollees will be impaired if a health carrier is required to continue enrollment of additional eligible individuals.

Sec. 14. RCW 48.43.025 and 1995 c 265 s 6 are each amended to read as follows:

(1) <u>For group health benefit plans, n</u>o 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~~)) twelve-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within ((~~three~~)) six months before the effective date of coverage.

(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.

Sec. 15. RCW 48.43.035 and 1995 c 265 s 7 are each amended to read as follows:

For group contracts, the following shall apply:

(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. 16.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Except as provided in subsection (4) of this section, all individual 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.

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

(a) Nonpayment of premium;

(b) Violation of a carrier's published policies approved by the 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.

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

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

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

(c) A carrier discontinues offering a particular type of health benefit plan offered in the individual market if: (i) The carrier provides notice to each covered individual provided coverage of this type of such discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each individual provided coverage of this type the option to enroll in any other individual health benefit plan currently being offered by the carrier; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage; or

(d) A carrier discontinues offering all individual health coverage in the state and discontinues coverage under all existing individual

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

(4) The provisions of this section do not apply to health plans deemed by the 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 commissioner.

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

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

Sec. 18. RCW 48.44.020 and 1990 c 120 s 5 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 19.** A new section is added to chapter 48.20 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) A certification by a member of the American academy of actuaries, or an officer of the carrier acceptable to the commissioner, that the adjusted community rate charged can be reasonably expected to result in a loss ratio that meets or exceeds the loss ratio standard established in subsection (7) of this section.

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

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

(a) At the expiration of a thirty-day period commencing with the date the filing is delivered to the commissioner, the filing shall be deemed approved unless prior thereto the commissioner contests the calculation of the actual loss ratio. If the commissioner contests the calculation of the actual loss ratio, the commissioner shall state in writing the grounds for contesting the calculation to the insurer and notify the carrier within thirty days.

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

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

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

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

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

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

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

Sec. 20. RCW 48.18.110 and 1985 c 264 s 9 are each amended to read as follows:

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

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

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

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

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

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

(2) In addition to the grounds for disapproval of any such form as provided in subsection (1) of this section, the commissioner may disapprove any form of disability insurance policy, except an

individual health benefit plan, if the benefits provided therein are unreasonable in relation to the premium charged.

NEW SECTION. **Sec. 21.** A new section is added to chapter 48.44 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Any dispute regarding the calculation of the actual loss ratio shall upon written demand of either the commissioner or the health care

service contractor be submitted to hearing under chapters 48.04 and 34.05 RCW.

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

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

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

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

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

(7) The loss ratio applicable to this section shall be seventy-two percent minus the premium tax rate applicable to the health care service contractor's individual contracts under RCW 48.14.0201.

Sec. 22. RCW 48.44.022 and 1997 c 231 s 208 are each amended to read as follows:

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

~~health plan shall clearly disclose these differences to the individual in a brochure approved by the commissioner.~~

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 23. RCW 48.44.130 and 1961 c 197 s 10 are each amended to read as follows:

No health care service contractor nor any individual acting on behalf thereof shall guarantee or agree to the payment of future dividends or future refunds of unused charges or savings in any specific or approximate amounts or percentages in respect to any contract being offered to the public, except in a group contract containing an experience refund provision or in compliance with RCW 48.44.022.

Sec. 24. RCW 48.46.060 and 1989 c 10 s 10 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

(5) No health maintenance organization authorized under this chapter shall cancel or fail to renew the enrollment on any basis of an enrolled participant or refuse to transfer an enrolled participant from a group to an individual basis for reasons relating solely to age, sex, race, or health status((~~: PROVIDED HOWEVER, That~~)). N~~n~~othing contained herein shall prevent cancellation of an agreement with enrolled participants (a) who violate any published policies of the organization which have been approved by the commissioner, or (b) who are entitled to become eligible for medicare benefits and fail to enroll for a medicare supplement plan offered by the health maintenance organization and approved by the commissioner, or (c) for failure of such enrolled participant to pay the approved charge, including cost-sharing, required under such contract, or (d) for a material breach of the health maintenance agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Any remittance required to be issued under this section shall be issued within thirty days after the actual loss ratio is deemed

approved under subsection (5)(a) of this section or the determination by an administrative law judge under subsection (5)(c) of this section.

(7) The loss ratio applicable to this section shall be seventy-two percent minus the premium tax rate applicable to the health maintenance organization's individual contracts under RCW 48.14.0201.

Sec. 26. RCW 48.46.064 and 1997 c 231 s 209 are each amended to read as follows:

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

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

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

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

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 27. RCW 48.46.300 and 1983 c 106 s 8 are each amended to read as follows:

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

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

Sec. 28. RCW 70.47.010 and 1993 c 492 s 208 are each amended to read as follows:

(1)(a) The legislature finds that limitations on access to health care services for enrollees in the state, such as in rural and underserved areas, are particularly challenging for the basic health plan. It is the intent of the legislature to authorize the administrator to develop alternative purchasing strategies to ensure access to basic health plan enrollees in all areas of the state, including the use of differential rating for managed health care systems based on geographic differences in costs.

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

enrollees followed, in priority order, by preferred providers, fee for service, and self-funding.

(2) The legislature further finds that:

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

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

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

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

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

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

proved that local health care providers are willing to enter into a public-private partnership as a managed care system.

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

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

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

Sec. 29. RCW 70.47.020 and 1997 c 335 s 1 are each amended to read as follows:

As used in this chapter:

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

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

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

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

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

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

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

Sec. 30. RCW 70.47.060 and 1998 c 314 s 17 and 1998 c 148 s 1 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

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

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

continuity of care after diagnosis of pregnancy by the managed care provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 31. RCW 70.47.100 and 1987 1st ex.s. c 5 s 12 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 32.** A new section is added to chapter 48.01 RCW to read as follows:

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

(2) Nothing in this title shall be construed to require a carrier, as defined in RCW 48.43.005, to offer any health benefit plan for sale or to prohibit a carrier from ceasing sale of any or all health benefit plans to new enrollees.

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

NEW SECTION. **Sec. 33.** RCW 48.41.180 (Offer of coverage to eligible persons) and 1987 c 431 s 18 are each repealed.

NEW SECTION. **Sec. 34.** 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. 35.** This act takes effect July 1, 2000.

--- END ---