S-2867.2

SENATE BILL 6103

State of Washington 56th Legislature 1999 Regular Session

By Senators Thibaudeau, Deccio, Winsley and Wojahn

Read first time 04/20/1999. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to access to individual health insurance coverage; amending RCW 48.04.010, 48.20.028, 48.41.020, 48.41.030, 48.41.040, 48.41.060, 48.41.080, 48.41.090, 48.41.100, 48.41.110, 48.41.120, 48.41.130, 48.41.140, 48.41.200, 48.43.015, 48.43.025, 48.43.035, 48.44.020, 48.44.022, 48.46.060, 48.46.064, 70.47.100, 43.84.092, and 43.84.092; reenacting and amending RCW 48.43.005 and 70.47.060; adding new sections 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 48.44 RCW; adding a new section to chapter 48.01 RCW; creating new sections; repealing RCW 48.41.180; making appropriations; providing an expiration date; and declaring an emergency.

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) Any hearing held relating to section 27 or 30 of this act shall be presided over by an administrative law judge assigned under chapter 34.12 RCW.

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 48.41.020 and 1987 c 431 s 2 are each amended to read as follows:

It is the purpose and intent of the legislature to provide access to health insurance coverage to all residents of Washington who are denied ((~~adequate~~)) health insurance ((~~for any reason~~)). ((~~It is the intent of the legislature that adequate levels of health insurance coverage be made available to residents of Washington who are otherwise considered uninsurable or who are underinsured.~~)) It is the intent of the Washington state health insurance coverage access act to provide a mechanism to ((~~insure~~)) ensure the availability of comprehensive health insurance to persons unable to obtain such insurance coverage on either an individual or group basis directly under any health plan.

Sec. 4. 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 or stop loss 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) "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. 5. RCW 48.41.040 and 1989 c 121 s 2 are each amended to read as follows:

(1) There is ((~~hereby~~)) created a nonprofit entity to be known as the Washington state health insurance pool. All members in this state on or after May 18, 1987, shall be members of the pool. When authorized by federal law, all self-insured employers shall also be members of the pool.

(2) ((~~Pursuant to chapter 34.05 RCW the commissioner shall, within ninety days after May 18, 1987, give notice to all members of the time and place for the initial organizational meetings of the pool.~~)) A board of directors shall be established, which shall be comprised of ((~~nine~~)) eleven voting members. The ((~~commissioner~~)) governor shall select ((~~three~~)) five members of the board who shall represent (a) the general public, (b) health care providers, ((~~and~~)) (c) health insurance agents, (d) consumers, and (e) private health care purchasers. ((~~The remaining~~)) Five members of the board shall be selected by election from among the members of the pool((~~. The elected members shall~~)), and, to the extent possible, shall include at least one representative of health care service contractors, one representative of health maintenance organizations, and one representative of commercial insurers which provides disability insurance. The governor shall select one additional member of the board who shall serve as chair. When self-insured organizations become eligible for participation in

the pool, the membership of the board shall be increased to ((~~eleven and at least one member of the board shall represent the self-insurers~~)) thirteen. One of the new members shall be appointed by the governor, and one, who shall represent the self-insurers, shall be selected by election from among the members of the pool. The insurance commissioner shall serve as an ex officio nonvoting member.

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

(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing pursuant to chapter 34.05 RCW, approve the plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board or any time thereafter fails to submit acceptable amendments to the plan, the commissioner shall, within ninety days after notice and hearing pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

NEW SECTION. **Sec. 6.** Thirty days from the effective date of this section, the existing board of directors of the Washington state health insurance pool shall be dissolved, and the appointment or election of new members under RCW 48.41.040 shall be effective. For purposes of setting terms, the new members shall be treated as original members.

Sec. 7. 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) Designate the tool to be used as the standard health questionnaire under section 20 of this act. The tool must provide for an objective evaluation of an individual's health status, based upon specific health conditions. The tool shall be designed to allow each carrier to screen eight percent of its applicants for individual coverage into the pool;

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

((~~(6)~~)) (e) Establish procedures for the administration of the premium discounts provided under RCW 48.41.200; and

(f) Provide certification to the commissioner when assessments will exceed the threshold level established in section 34 of this act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. RCW 48.41.090 and 1989 c 121 s 6 are each amended to read as follows:

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

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction((~~,~~)). The numerator of ((~~which~~)) the fraction equals that member's total: Number of resident insured persons, including spouse and dependents under the member's health plans; plus the number of resident insured persons covered under stop loss policies issued to self-insured employer plans, minus; the number of insured persons covered under individual policies or contracts in the state during the preceding calendar year((~~, and~~)). The denominator of ((~~which~~)) the fraction equals the total number of resident insured persons including spouses and dependents insured under all health plans, including employer purchased stop loss policies, minus the number of insured persons covered under individual policies or contracts in the state by pool members.

(b) Except as provided in section 34 of this act, any deficit incurred by the pool shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members.

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

(4) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this

subsection, "future losses" includes reserves for incurred but not reported claims.

Sec. 10. 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~~)):

(a) Upon providing 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 20 of this act; or

(b) By direct application to and acceptance by the pool. Upon direct application, the administrator shall administer the standard health questionnaire. The administrator shall inform the individual whether he or she has been accepted for pool coverage within fifteen days of receipt of a completed application. Anyone not accepted for pool coverage shall be given information regarding other sources of health insurance in the state.

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

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

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

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

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

Sec. 11. RCW 48.41.110 and 1997 c 231 s 213 are each amended to read as follows:

(1) The pool ((~~is authorized to~~)) shall offer one or more ((~~managed~~)) care management 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~~)) 2000, may continue coverage under the pool plan in which they are enrolled on that date. However, the pool may incorporate managed care features into such existing plans.

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

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

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

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community

mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

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

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

(p) Hospice services;

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

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

((~~(3)~~)) (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 impose a three-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment, 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 19 of this act.

Sec. 12. 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.

Sec. 13. RCW 48.41.130 and 1997 c 231 s 215 are each amended to read as follows:

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

NEW SECTION. **Sec. 14.** 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. The board is authorized to deviate from those services if medically appropriate, cost-effective alternatives are available.

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

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

(2) A pool policy shall provide that coverage of a dependent, unmarried person shall terminate when the person becomes nineteen years of age: PROVIDED, That coverage of such person shall not terminate at age nineteen while he or she is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (b) chiefly dependent upon the person in whose name the policy is issued for support and maintenance, provided proof

of such incapacity and dependency is furnished to the pool by the policy holder within thirty-one days of the dependent's attainment of age nineteen and subsequently as may be required by the pool but not more frequently than annually after the two-year period following the dependent's attainment of age nineteen.

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

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

Sec. 16. 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 largest members, measured in terms of individual market enrollment, offering such coverages in the state ((~~comparable to the pool coverage~~)). In the event five members do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage 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;

(c) Maximum rates for any pool plan for a person who, within sixty-three days of his or her enrollment in the pool, has had at least twelve months of continuous previous coverage shall be the average rate calculated under subsection (1) of this section.

(3)(a) Subject to (b) of this subsection:

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

(ii) The rate for any person whose current gross family income is more than two hundred fifty but less than three hundred one percent of the federal poverty level shall be reduced by fifteen percent from what it would otherwise be;

(iii) The rate for any person who has been enrolled in the pool for more than thirty-six months shall be reduced by five percent from what it would otherwise be;

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

Sec. 17. 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)~~)) (21) "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)~~)) (22) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(22)~~)) (23) "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)~~)) (24) "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)~~)) (25) "Small employer" means any person, firm, corporation, partnership, association, political subdivision except school districts, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that

are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

((~~(25)~~)) (26) "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)~~)) (27) "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. 18. RCW 48.43.015 and 1995 c 265 s 5 are each amended to read as follows:

(1) For group health benefit plans, every health carrier shall waive any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different health plan at any time during the three-month period immediately preceding the date of application for the new health plan if such person was continuously covered under the immediately preceding health plan. If the person was continuously covered for at least three months under the immediately preceding health plan, the carrier may not impose a waiting period for coverage of preexisting conditions. If the person was continuously

covered for less than three months under the immediately preceding health plan, the carrier must credit any waiting period under the immediately preceding health plan toward the new health plan. For the purposes of this subsection, a preceding health plan includes an employer provided self-funded health plan.

(2) Subject to the provisions of 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. 19.** 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 and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions except as provided in this section.

(2) Preexisting condition waiting periods imposed upon a person enrolling in individual coverage shall be no more restrictive than the following:

(a) For individual coverage originally issued on or after the effective date of this section, nine months for a preexisting condition 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 six months prior to the effective date of coverage.

(b) For individual coverage originally issued on or after October 1, 2000, at the choice of the person seeking coverage:

(i) Nine months for a preexisting condition 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 six months prior to the effective date of coverage; or

(ii) Six months for a preexisting condition 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 six months prior to the effective date of coverage. However, between the seventh and twelfth month of coverage, inclusive, the carrier may impose cost-sharing for coverage of the preexisting condition in excess of that otherwise applicable to the underlying coverage. The additional preexisting condition cost-sharing shall not exceed a deductible of one thousand five hundred dollars, and coinsurance of eighty percent, up to a maximum out-of-pocket expenditure of four thousand five hundred dollars. The maximum out-of-pocket expenditure for the additional preexisting condition cost-sharing shall be adjusted annually according to the inflation rate identified by the annual consumer price index, as certified by the office of financial management.

(iii) The enrollee shall select the option upon application.

(3) Individual coverage preexisting condition exclusion waiting periods shall not apply to prenatal care services.

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

NEW SECTION. **Sec. 20.** 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 seeking individual coverage due to his or her relocating to a geographic area where their current health coverage is not offered, completion of the standard health questionnaire shall not be a condition of coverage.

(b) If a person is seeking 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 individual coverage; and

(ii) His or her health care provider is part of another carrier's 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 for coverage under the Washington state health insurance pool, the carrier may decide not to accept the person's application for enrollment in its individual health plan, subject to (c) of this subsection.

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

(c) Based upon application of the standardized health questionnaire, a carrier may decide not to issue coverage to up to eight percent of its applicants for individual health plans each calendar year.

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

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

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

Sec. 22. RCW 48.43.035 and 1995 c 265 s 7 are each amended to read as follows:

(1) All health carriers shall accept for enrollment any state resident within the carrier's service area and provide or assure the provision of all covered services regardless of age, sex, family structure, ethnicity, race, health condition, 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.

(6) This section shall not apply to individual health benefit plans.

NEW SECTION. **Sec. 23.** 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 published policies of the carrier 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 insurance coverage 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 insurance coverage 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. 24.** A new section is added to chapter 48.43 RCW to read as follows:

Any individual health plan other than a catastrophic health plan offered to new applicants on or after January 1, 2000, shall include benefits described in this subsection. Nothing in this section shall be construed to require a carrier to offer individual coverage.

(1) Maternity services that include, with no enrollee cost-sharing requirements beyond those generally applicable cost sharing requirements and those cost sharing requirements that apply to preexisting conditions: Diagnosis of pregnancy; prenatal care; delivery; care for complications of pregnancy; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; appropriate medications; anesthesia; and services required under RCW 48.43.115; and

(2) Prescription drug benefits with at least a two thousand dollar benefit payable by the carrier annually.

NEW SECTION. **Sec. 25.** 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. 26. 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. 27.** 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) "Incurred claims expense" means claims paid plus the change in claims reserves and liabilities.

(b) "Incurred health care expense" means claims paid plus the health care costs incurred in the delivery of health care services plus the change in claims reserves and liabilities.

(c) "Loss ratio" means the ratio of incurred claims expense or incurred health care expense to earned premium stated on a percentage basis.

(2) A health care service contractor 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 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, refunds are due and the following shall apply:

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

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

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

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

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

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

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

Sec. 28. 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. 29. 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~~)). Nothing contained herein shall prevent cancellation of an agreement with enrolled participants (a) who violate any published policies of the organization which have been approved by the commissioner, or (b) who are entitled to become eligible for medicare benefits and fail to enroll for a medicare supplement plan offered by the health maintenance organization and approved by the commissioner, or (c) for failure of such enrolled participant to pay the approved charge, including cost-sharing, required under such contract, or (d) for a material breach of the health maintenance agreement.

((~~(5)~~)) (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. 30.** 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) "Incurred claims expense" means claims paid plus the change in claims reserves and liabilities.

(b) "Incurred health care expense" means claims paid plus the health care costs incurred in the delivery of health care services plus the change in claims reserves and liabilities.

(c) "Loss ratio" means the ratio of incurred claims expense or incurred health care expense to earned premium stated on a percentage basis.

(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, refunds are due and the following shall apply:

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

(b) The refund due to each enrollee 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 refund due at a five percent annual rate calculated from the end of the calendar year for which refunds are due to the date the refunds are made.

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

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

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

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

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

Sec. 31. 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. 32. 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 <u>for either subsidized enrollees, or nonsubsidized enrollees, or both</u>. 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. 33. 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.

NEW SECTION. **Sec. 34.** A new section is added to chapter 48.41 RCW to read as follows:

The Washington state health insurance pool account is created in the custody of the state treasurer. All receipts from moneys specifically appropriated to the account must be deposited in the account. Expenditures from the account may be used only to cover deficits incurred by the Washington state health insurance pool under

this chapter in excess of the threshold established in this section. To the extent funds are available in the account, funds shall be expended from the account only to offset that portion of the deficit that would otherwise have to be recovered by imposing an assessment on members in excess of a threshold of seventy cents per insured person per month. The commissioner shall authorize expenditures from the account, to the extent that funds are available in the account, upon certification by the pool board that assessments will exceed the threshold level established in this section. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

Sec. 35. RCW 43.84.092 and 1997 c 218 s 5 are each amended to read as follows:

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

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

(3) Except for the provisions of RCW 43.84.160, the treasury income account may be utilized for the payment of purchased banking services on behalf of treasury funds including, but not limited to, depository, safekeeping, and disbursement functions for the state treasury and affected state agencies. The treasury income account is subject in all respects to chapter 43.88 RCW, but no appropriation is required for

payments to financial institutions. Payments shall occur prior to distribution of earnings set forth in subsection (4) of this section.

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

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the drinking water assistance account, the Eastern Washington University capital projects account, the education construction fund, the emergency reserve fund, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the highway infrastructure account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the medical aid account, the mobile home park relocation fund, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system plan 2 account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan 1 account, the teachers' retirement system plan

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

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

the transportation equipment fund, the transportation fund, the transportation improvement account, the transportation revolving loan account, and the urban arterial trust account.

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

Sec. 36. RCW 43.84.092 and 1998 c 341 s 708 are each amended to read as follows:

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

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

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

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

(a) The following accounts and funds shall receive their proportionate share of earnings based upon each account's and fund's average daily balance for the period: The capitol building construction account, the Cedar River channel construction and operation account, the Central Washington University capital projects account, the charitable, educational, penal and reformatory institutions account, the common school construction fund, the county criminal justice assistance account, the county sales and use tax equalization account, the data processing building construction account, the deferred compensation administrative account, the deferred compensation principal account, the department of retirement systems expense account, the drinking water assistance account, the Eastern Washington University capital projects account, the education construction fund, the emergency reserve fund, the federal forest revolving account, the health services account, the public health services account, the health system capacity account, the personal health services account, the highway infrastructure account, the industrial insurance premium refund account, the judges' retirement account, the judicial retirement administrative account, the judicial retirement principal account, the local leasehold excise tax account, the local real estate excise tax account, the local sales and use tax account, the medical aid account, the mobile home park relocation fund, the municipal criminal justice assistance account, the municipal sales and use tax equalization account, the natural resources deposit account, the perpetual surveillance and maintenance account, the public employees' retirement system plan 1 account, the public employees' retirement system plan 2 account, the Puyallup tribal settlement account, the resource management cost account, the site closure account, the special wildlife account, the state employees' insurance account, the state employees' insurance reserve account, the state investment board expense account, the state investment board commingled trust fund accounts, the supplemental pension account, the teachers' retirement system plan 1 account, the teachers' retirement system combined plan 2 and plan 3 account, the transportation infrastructure account, the tuition recovery trust fund, the University of Washington bond retirement fund, the University of Washington building account, the volunteer fire fighters' relief and pension principal account, the volunteer fire fighters' relief and pension administrative account, the Washington judicial retirement system account, the Washington law

enforcement officers' and fire fighters' system plan 1 retirement account, the Washington law enforcement officers' and fire fighters' system plan 2 retirement account, the Washington school employees' retirement system combined plan 2 and 3 account, the Washington state health insurance pool account, the Washington state patrol retirement account, the Washington State University building account, the Washington State University bond retirement fund, the water pollution control revolving fund, and the Western Washington University capital projects account. Earnings derived from investing balances of the agricultural permanent fund, the normal school permanent fund, the permanent common school fund, the scientific permanent fund, and the state university permanent fund shall be allocated to their respective beneficiary accounts. All earnings to be distributed under this subsection (4)(a) shall first be reduced by the allocation to the state treasurer's service fund pursuant to RCW 43.08.190.

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

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

NEW SECTION. **Sec. 37.** A new section is added to chapter 48.01 RCW to read as follows:

(1) 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.

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

NEW SECTION. **Sec. 38.** (1) The task force on health care reinsurance is created, and is composed of seven members, including: Three members appointed by the governor, one of whom shall be the chair of the Washington state health insurance pool; two members of the senate, one member of each party caucus appointed by the president of the senate; and two members of the house of representatives, one member of each party caucus appointed by the co-speakers of the house of representatives. The chair shall be elected by the task force from among its members.

(2) The task force shall:

(a) Monitor the provisions of this act regarding its effect on:

(i) Carrier participation in the individual market, especially in areas where coverage is currently minimal;

(ii) Affordability and availability of private health plan coverage;

(iii) Washington state health insurance pool operations; and

(iv) The Washington basic health plan operations;

(b) After studying the feasibility of reinsurance as a method of health insurance market stability, develop a reinsurance system implementation plan as appropriate; and

(c) Seek participation from interested parties, including but not limited to consumer, carriers, health care providers, health care purchasers, and insurance brokers and agents, in an effective manner.

(3) In the conduct of its business, the task force shall have access to all health data available by statute to health-related state

agencies and may, to the extent that funds are available, purchase necessary analytical and staff support.

(4) Task force members will receive no compensation for their service.

(5) The task force shall submit an interim report to the governor and the legislature in January 2000 and a final report no later than December 1, 2000.

(6) The task force expires December 31, 2000.

NEW SECTION. **Sec. 39.** (1) The sum of seventy-five thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2000, from the general fund to the task force on health care reinsurance created in section 38 of this act.

(2) The sum of fifty thousand dollars, or as much thereof as may be necessary, is appropriated for the fiscal year ending June 30, 2001, from the general fund to the task force on health care reinsurance created in section 38 of this act.

NEW SECTION. **Sec. 40.** This act expires January 1, 2004.

NEW SECTION. **Sec. 41.** RCW 48.41.180 (Offer of coverage to eligible persons) and 1987 c 431 s 18 are each repealed.

NEW SECTION. **Sec. 42.** 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. 43.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

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