

CERTIFICATION OF ENROLLMENT

HOUSE BILL 1633

57th Legislature
2001 Regular Legislative Session

Passed by the House April 16, 2001
Yeas 94 Nays 0

Speaker of the House of Representatives

Speaker of the House of Representatives

Passed by the Senate April 11, 2001
Yeas 47 Nays 0

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

We, Timothy A. Martin and Cynthia Zehnder, Co-Chief Clerks of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 1633** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

Chief Clerk

FILED

**Secretary of State
State of Washington**

HOUSE BILL 1633

AS AMENDED BY THE SENATE

Passed Legislature - 2001 Regular Session

State of Washington 57th Legislature 2001 Regular Session

By Representatives Campbell and Cody; by request of Insurance
Commissioner

Read first time 01/31/2001. Referred to Committee on Health Care.

1 AN ACT Relating to technical corrections to chapters 79 and 80,
2 Laws of 2000; amending RCW 48.20.025, 48.41.030, 48.41.100, 48.41.110,
3 48.43.005, 48.43.012, 48.43.015, 48.43.018, 48.43.025, 48.44.017,
4 48.46.062, and 70.47.060; adding a new section to chapter 48.43 RCW;
5 and declaring an emergency.

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

7 **Sec. 1.** RCW 48.20.025 and 2000 c 79 s 3 are each amended to read
8 as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 (5) By the last day of May each year any insurer (~~providing~~)
36 issuing or renewing individual health benefit plans in this state
37 during the preceding calendar year shall file for review by the
38 commissioner supporting documentation of its actual loss ratio for its
39 individual health benefit plans offered or renewed in the state in

1 aggregate for the preceding calendar year. The filing shall include
2 aggregate earned premiums, aggregate incurred claims, and a
3 certification by a member of the American academy of actuaries, or
4 other person approved by the commissioner, that the actual loss ratio
5 has been calculated in accordance with accepted actuarial principles.

6 (a) At the expiration of a thirty-day period beginning with the
7 date the filing is (~~delivered to~~) received by the commissioner, the
8 filing shall be deemed approved unless prior thereto the commissioner
9 contests the calculation of the actual loss ratio.

10 (b) If the commissioner contests the calculation of the actual loss
11 ratio, the commissioner shall state in writing the grounds for
12 contesting the calculation to the insurer.

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

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

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

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

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

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

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

1 **Sec. 2.** RCW 48.41.030 and 2000 c 79 s 6 are each amended to read
2 as follows:

3 The definitions in this section apply throughout this chapter
4 unless the context clearly requires otherwise.

5 (1) "Accounting year" means a twelve-month period determined by the
6 board for purposes of record-keeping and accounting. The first
7 accounting year may be more or less than twelve months and, from time
8 to time in subsequent years, the board may order an accounting year of
9 other than twelve months as may be required for orderly management and
10 accounting of the pool.

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

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

14 (4) "Commissioner" means the insurance commissioner.

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

18 (6) "Health care facility" has the same meaning as in RCW
19 70.38.025.

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

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

25 (9) "Health carrier" or "carrier" has the same meaning as in RCW
26 48.43.005.

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

1 statutorily required to be contained in any liability insurance policy
2 or equivalent self-insurance.

3 (11) "Health plan" means any arrangement by which persons,
4 including dependents or spouses, covered or making application to be
5 covered under this pool, have access to hospital and medical benefits
6 or reimbursement including any group or individual disability insurance
7 policy; health care service contract; health maintenance agreement;
8 uninsured arrangements of group or group-type contracts including
9 employer self-insured, cost-plus, or other benefit methodologies not
10 involving insurance or not governed by Title 48 RCW; coverage under
11 group-type contracts which are not available to the general public and
12 can be obtained only because of connection with a particular
13 organization or group; and coverage by medicare or other governmental
14 benefits. This term includes coverage through "health coverage" as
15 defined under this section, and specifically excludes those types of
16 programs excluded under the definition of "health coverage" in
17 subsection (10) of this section.

18 (12) "Medical assistance" means coverage under Title XIX of the
19 federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and chapter
20 74.09 RCW.

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

23 (14) "Member" means any commercial insurer which provides
24 disability insurance or stop loss insurance, any health care service
25 contractor, and any health maintenance organization licensed under
26 Title 48 RCW. "Member" also means the Washington state health care
27 authority as issuer of the state uniform medical plan. "Member" shall
28 also mean, as soon as authorized by federal law, employers and other
29 entities, including a self-funding entity and employee welfare benefit
30 plans that provide health plan benefits in this state on or after May
31 18, 1987. "Member" does not include any insurer, health care service
32 contractor, or health maintenance organization whose products are
33 exclusively dental products or those products excluded from the
34 definition of "health coverage" set forth in subsection (10) of this
35 section.

36 (15) "Network provider" means a health care provider who has
37 contracted in writing with the pool administrator or a health carrier
38 contracting with the pool administrator to offer pool coverage to

1 accept payment from and to look solely to the pool or health carrier
2 according to the terms of the pool health plans.

3 (16) "Plan of operation" means the pool, including articles, by-
4 laws, and operating rules, adopted by the board pursuant to RCW
5 48.41.050.

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

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

12 **Sec. 3.** RCW 48.41.100 and 2000 c 79 s 12 are each amended to read
13 as follows:

14 (1) The following persons who are residents of this state are
15 eligible for pool coverage:

16 (a) Any person who provides evidence of a carrier's decision not to
17 accept him or her for enrollment in an individual health benefit plan
18 as defined in RCW 48.43.005 based upon, and within ninety days of the
19 receipt of, the results of the standard health questionnaire designated
20 by the board and administered by health carriers under RCW 48.43.018;

21 (b) Any person who continues to be eligible for pool coverage based
22 upon the results of the standard health questionnaire designated by the
23 board and administered by the pool administrator pursuant to subsection
24 (3) of this section;

25 (c) Any person who resides in a county of the state where no
26 carrier or insurer (~~regulated~~) eligible under chapter 48.15 RCW
27 offers to the public an individual health benefit plan other than a
28 catastrophic health plan as defined in RCW 48.43.005 at the time of
29 application to the pool, and who makes direct application to the pool;
30 and

31 (d) Any medicare eligible person upon providing evidence of
32 rejection for medical reasons, a requirement of restrictive riders, an
33 up-rated premium, or a preexisting conditions limitation on a medicare
34 supplemental insurance policy under chapter 48.66 RCW, the effect of
35 which is to substantially reduce coverage from that received by a
36 person considered a standard risk by at least one member within six
37 months of the date of application.

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

3 (a) Any person having terminated coverage in the pool unless (i)
4 twelve months have lapsed since termination, or (ii) that person can
5 show continuous other coverage which has been involuntarily terminated
6 for any reason other than nonpayment of premiums. However, these
7 exclusions do not apply to eligible individuals as defined in section
8 2741(b) of the federal health insurance portability and accountability
9 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

10 (b) Any person on whose behalf the pool has paid out one million
11 dollars in benefits;

12 (c) Inmates of public institutions and persons whose benefits are
13 duplicated under public programs. However, these exclusions do not
14 apply to eligible individuals as defined in section 2741(b) of the
15 federal health insurance portability and accountability act of 1996 (42
16 U.S.C. Sec. 300gg-41(b));

17 (d) Any person who resides in a county of the state where any
18 carrier or insurer regulated under chapter 48.15 RCW offers to the
19 public an individual health benefit plan other than a catastrophic
20 health plan as defined in RCW 48.43.005 at the time of application to
21 the pool and who does not qualify for pool coverage based upon the
22 results of the standard health questionnaire, or pursuant to subsection
23 (1)(d) of this section.

24 (3) When a carrier or insurer regulated under chapter 48.15 RCW
25 begins to offer an individual health benefit plan in a county where no
26 carrier had been offering an individual health benefit plan:

27 (a) If the health benefit plan offered is other than a catastrophic
28 health plan as defined in RCW 48.43.005, any person enrolled in a pool
29 plan pursuant to subsection (1)(c) of this section in that county shall
30 no longer be eligible for coverage under that plan pursuant to
31 subsection (1)(c) of this section, but may continue to be eligible for
32 pool coverage based upon the results of the standard health
33 questionnaire designated by the board and administered by the pool
34 administrator. The pool administrator shall offer to administer the
35 questionnaire to each person no longer eligible for coverage under
36 subsection (1)(c) of this section within thirty days of determining
37 that he or she is no longer eligible;

1 (b) Losing eligibility for pool coverage under this subsection (3)
2 does not affect a person's eligibility for pool coverage under
3 subsection (1)(a), (b), or (d) of this section; and

4 (c) The pool administrator shall provide written notice to any
5 person who is no longer eligible for coverage under a pool plan under
6 this subsection (3) within thirty days of the administrator's
7 determination that the person is no longer eligible. The notice shall:
8 (i) Indicate that coverage under the plan will cease ninety days from
9 the date that the notice is dated; (ii) describe any other coverage
10 options, either in or outside of the pool, available to the person;
11 (iii) describe the procedures for the administration of the standard
12 health questionnaire to determine the person's continued eligibility
13 for coverage under subsection (1)(b) of this section; and (iv) describe
14 the enrollment process for the available options outside of the pool.

15 **Sec. 4.** RCW 48.41.110 and 2000 c 80 s 2 are each amended to read
16 as follows:

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

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

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

37 (a) Hospital services, including charges for the most common
38 semiprivate room, for the most common private room if semiprivate rooms

1 do not exist in the health care facility, or for the private room if
2 medically necessary, but limited to a total of one hundred eighty
3 inpatient days in a calendar year, and limited to thirty days inpatient
4 care for mental and nervous conditions, or alcohol, drug, or chemical
5 dependency or abuse per calendar year;

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

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

20 (d) Drugs and contraceptive devices requiring a prescription;

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

24 (f) Services of a home health agency;

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

27 (h) Oxygen;

28 (i) Anesthesia services;

29 (j) Prostheses, other than dental;

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

32 (l) Diagnostic x-rays and laboratory tests;

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

1 (n) Maternity care services;

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

4 (p) Hospice services;

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

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

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

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

23 (6) The pool may not reject an individual for health plan coverage
24 based upon preexisting conditions of the individual or deny, exclude,
25 or otherwise limit coverage for an individual's preexisting health
26 conditions; except that it shall impose a six-month benefit waiting
27 period for preexisting conditions for which medical advice was given,
28 for which a health care provider recommended or provided treatment, or
29 for which a prudent layperson would have sought advice or treatment,
30 within six months before the effective date of coverage. The
31 preexisting condition waiting period shall not apply to prenatal care
32 services. The pool may not avoid the requirements of this section
33 through the creation of a new rate classification or the modification
34 of an existing rate classification. Credit against the waiting period
35 shall be as provided in subsection (7) of this section.

36 (7)(a) Except as provided in (b) of this subsection, the pool shall
37 credit any preexisting condition waiting period in its plans for a
38 person who was enrolled at any time during the sixty-three day period
39 immediately preceding the date of application for the new pool plan

1 (~~(in a group health benefit plan or an individual health benefit plan~~
2 ~~other than a catastrophic health plan. The pool must credit the period~~
3 ~~of coverage the person was continuously covered under the immediately~~
4 ~~preceding health plan)). For the person previously enrolled in a group~~
5 ~~health benefit plan, the pool must credit the aggregate of all periods~~
6 ~~of preceding coverage not separated by more than sixty-three days~~
7 ~~toward the waiting period of the new health plan. For the person~~
8 ~~previously enrolled in an individual health benefit plan other than a~~
9 ~~catastrophic health plan, the pool must credit the period of coverage~~
10 ~~the person was continuously covered under the immediately preceding~~
11 ~~health plan toward the waiting period of the new health plan. For the~~
12 purposes of this subsection, a preceding health plan includes an
13 employer-provided self-funded health plan.

14 (b) The pool shall waive any preexisting condition waiting period
15 for a person who is an eligible individual as defined in section
16 2741(b) of the federal health insurance portability and accountability
17 act of 1996 (42 U.S.C. 300gg-41(b)).

18 (8) If an application is made for the pool policy as a result of
19 rejection by a carrier, then the date of application to the carrier,
20 rather than to the pool, should govern for purposes of determining
21 preexisting condition credit.

22 **Sec. 5.** RCW 48.43.005 and 2000 c 79 s 18 are each amended to read
23 as follows:

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

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

30 (2) "Basic health plan" means the plan described under chapter
31 70.47 RCW, as revised from time to time.

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

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

38 ~~((4))~~ (5) "Catastrophic health plan" means:

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

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

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

18 ((+5)) (6) "Certification" means a determination by a review
19 organization that an admission, extension of stay, or other health care
20 service or procedure has been reviewed and, based on the information
21 provided, meets the clinical requirements for medical necessity,
22 appropriateness, level of care, or effectiveness under the auspices of
23 the applicable health benefit plan.

24 ((+6)) (7) "Concurrent review" means utilization review conducted
25 during a patient's hospital stay or course of treatment.

26 ((+7)) (8) "Covered person" or "enrollee" means a person covered
27 by a health plan including an enrollee, subscriber, policyholder,
28 beneficiary of a group plan, or individual covered by any other health
29 plan.

30 ((+8)) (9) "Dependent" means, at a minimum, the enrollee's legal
31 spouse and unmarried dependent children who qualify for coverage under
32 the enrollee's health benefit plan.

33 ((+9)) (10) "Eligible employee" means an employee who works on a
34 full-time basis with a normal work week of thirty or more hours. The
35 term includes a self-employed individual, including a sole proprietor,
36 a partner of a partnership, and may include an independent contractor,
37 if the self-employed individual, sole proprietor, partner, or
38 independent contractor is included as an employee under a health
39 benefit plan of a small employer, but does not work less than thirty

1 hours per week and derives at least seventy-five percent of his or her
2 income from a trade or business through which he or she has attempted
3 to earn taxable income and for which he or she has filed the
4 appropriate internal revenue service form. Persons covered under a
5 health benefit plan pursuant to the consolidated omnibus budget
6 reconciliation act of 1986 shall not be considered eligible employees
7 for purposes of minimum participation requirements of chapter 265, Laws
8 of 1995.

9 ~~((10))~~ (11) "Emergency medical condition" means the emergent and
10 acute onset of a symptom or symptoms, including severe pain, that would
11 lead a prudent layperson acting reasonably to believe that a health
12 condition exists that requires immediate medical attention, if failure
13 to provide medical attention would result in serious impairment to
14 bodily functions or serious dysfunction of a bodily organ or part, or
15 would place the person's health in serious jeopardy.

16 ~~((11))~~ (12) "Emergency services" means otherwise covered health
17 care services medically necessary to evaluate and treat an emergency
18 medical condition, provided in a hospital emergency department.

19 ~~((12))~~ (13) "Enrollee point-of-service cost-sharing" means
20 amounts paid to health carriers directly providing services, health
21 care providers, or health care facilities by enrollees and may include
22 copayments, coinsurance, or deductibles.

23 ~~((13))~~ (14) "Grievance" means a written complaint submitted by or
24 on behalf of a covered person regarding: (a) Denial of payment for
25 medical services or nonprovision of medical services included in the
26 covered person's health benefit plan, or (b) service delivery issues
27 other than denial of payment for medical services or nonprovision of
28 medical services, including dissatisfaction with medical care, waiting
29 time for medical services, provider or staff attitude or demeanor, or
30 dissatisfaction with service provided by the health carrier.

31 ~~((14))~~ (15) "Health care facility" or "facility" means hospices
32 licensed under chapter 70.127 RCW, hospitals licensed under chapter
33 70.41 RCW, rural health care facilities as defined in RCW 70.175.020,
34 psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes
35 licensed under chapter 18.51 RCW, community mental health centers
36 licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment
37 centers licensed under chapter 70.41 RCW, ambulatory diagnostic,
38 treatment, or surgical facilities licensed under chapter 70.41 RCW,
39 drug and alcohol treatment facilities licensed under chapter 70.96A

1 RCW, and home health agencies licensed under chapter 70.127 RCW, and
2 includes such facilities if owned and operated by a political
3 subdivision or instrumentality of the state and such other facilities
4 as required by federal law and implementing regulations.

5 ~~((15))~~ (16) "Health care provider" or "provider" means:

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

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

11 ~~((16))~~ (17) "Health care service" means that service offered or
12 provided by health care facilities and health care providers relating
13 to the prevention, cure, or treatment of illness, injury, or disease.

14 ~~((17))~~ (18) "Health carrier" or "carrier" means a disability
15 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
16 service contractor as defined in RCW 48.44.010, or a health maintenance
17 organization as defined in RCW 48.46.020.

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

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

23 (b) Medicare supplemental health insurance governed by chapter
24 48.66 RCW;

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

27 (d) Disability income;

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

31 (f) Workers' compensation coverage;

32 (g) Accident only coverage;

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

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

36 (j) Dental only and vision only coverage; and

37 (k) Plans deemed by the insurance commissioner to have a short-term
38 limited purpose or duration, or to be a student-only plan that is
39 guaranteed renewable while the covered person is enrolled as a regular

1 full-time undergraduate or graduate student at an accredited higher
2 education institution, after a written request for such classification
3 by the carrier and subsequent written approval by the insurance
4 commissioner.

5 ~~((19))~~ (20) "Material modification" means a change in the
6 actuarial value of the health plan as modified of more than five
7 percent but less than fifteen percent.

8 ~~((20))~~ (21) "Preexisting condition" means any medical condition,
9 illness, or injury that existed any time prior to the effective date of
10 coverage.

11 ~~((21))~~ (22) "Premium" means all sums charged, received, or
12 deposited by a health carrier as consideration for a health plan or the
13 continuance of a health plan. Any assessment or any "membership,"
14 "policy," "contract," "service," or similar fee or charge made by a
15 health carrier in consideration for a health plan is deemed part of the
16 premium. "Premium" shall not include amounts paid as enrollee point-
17 of-service cost-sharing.

18 ~~((22))~~ (23) "Review organization" means a disability insurer
19 regulated under chapter 48.20 or 48.21 RCW, health care service
20 contractor as defined in RCW 48.44.010, or health maintenance
21 organization as defined in RCW 48.46.020, and entities affiliated with,
22 under contract with, or acting on behalf of a health carrier to perform
23 a utilization review.

24 ~~((23))~~ (24) "Small employer" or "small group" means any person,
25 firm, corporation, partnership, association, political subdivision
26 except school districts, or self-employed individual that is actively
27 engaged in business that, on at least fifty percent of its working days
28 during the preceding calendar quarter, employed no more than fifty
29 eligible employees, with a normal work week of thirty or more hours,
30 the majority of whom were employed within this state, and is not formed
31 primarily for purposes of buying health insurance and in which a bona
32 fide employer-employee relationship exists. In determining the number
33 of eligible employees, companies that are affiliated companies, or that
34 are eligible to file a combined tax return for purposes of taxation by
35 this state, shall be considered an employer. Subsequent to the
36 issuance of a health plan to a small employer and for the purpose of
37 determining eligibility, the size of a small employer shall be
38 determined annually. Except as otherwise specifically provided, a
39 small employer shall continue to be considered a small employer until

1 the plan anniversary following the date the small employer no longer
2 meets the requirements of this definition. The term "small employer"
3 includes a self-employed individual or sole proprietor. The term
4 "small employer" also includes a self-employed individual or sole
5 proprietor who derives at least seventy-five percent of his or her
6 income from a trade or business through which the individual or sole
7 proprietor has attempted to earn taxable income and for which he or she
8 has filed the appropriate internal revenue service form 1040, schedule
9 C or F, for the previous taxable year.

10 ~~((+24))~~ (25) "Utilization review" means the prospective,
11 concurrent, or retrospective assessment of the necessity and
12 appropriateness of the allocation of health care resources and services
13 of a provider or facility, given or proposed to be given to an enrollee
14 or group of enrollees.

15 ~~((+25))~~ (26) "Wellness activity" means an explicit program of an
16 activity consistent with department of health guidelines, such as,
17 smoking cessation, injury and accident prevention, reduction of alcohol
18 misuse, appropriate weight reduction, exercise, automobile and
19 motorcycle safety, blood cholesterol reduction, and nutrition education
20 for the purpose of improving enrollee health status and reducing health
21 service costs.

22 **Sec. 6.** RCW 48.43.012 and 2000 c 79 s 19 are each amended to read
23 as follows:

24 (1) No carrier may reject an individual for an individual health
25 benefit plan based upon preexisting conditions of the individual except
26 as provided in RCW 48.43.018.

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

30 (3) For an individual health benefit plan originally issued on or
31 after March 23, 2000, preexisting condition waiting periods imposed
32 upon a person enrolling in an individual health benefit plan shall be
33 no more than nine months for a preexisting condition for which medical
34 advice was given, for which a health care provider recommended or
35 provided treatment, or for which a prudent layperson would have sought
36 advice or treatment, within six months prior to the effective date of
37 the plan. No carrier may impose a preexisting condition waiting period
38 on an individual health benefit plan issued to an eligible individual

1 as defined in section 2741(b) of the federal health insurance
2 portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

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

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

13 **Sec. 7.** RCW 48.43.015 and 2000 c 80 s 3 are each amended to read
14 as follows:

15 (1) ~~((For a health benefit plan offered to a group other than a~~
16 ~~small group, every health carrier shall reduce any preexisting~~
17 ~~condition exclusion or limitation for persons or groups who had similar~~
18 ~~health coverage under a different health plan at any time during the~~
19 ~~three-month period immediately preceding the date of application for~~
20 ~~the new health plan if such person was continuously covered under the~~
21 ~~immediately preceding health plan. If the person was continuously~~
22 ~~covered for at least three months under the immediately preceding~~
23 ~~health plan, the carrier may not impose a waiting period for coverage~~
24 ~~of preexisting conditions. If the person was continuously covered for~~
25 ~~less than three months under the immediately preceding health plan, the~~
26 ~~carrier must credit any waiting period under the immediately preceding~~
27 ~~health plan toward the new health plan. For the purposes of this~~
28 ~~subsection, a preceding health plan includes an employer-provided self-~~
29 ~~funded health plan and plans of the Washington state health insurance~~
30 ~~pool.~~

31 (2) ~~For a health benefit plan offered to a small group, every~~
32 ~~health carrier shall reduce any preexisting condition exclusion or~~
33 ~~limitation for persons or groups who had similar health coverage under~~
34 ~~a different health plan at any time during the three-month period~~
35 ~~immediately preceding the date of application for the new health plan~~
36 ~~if such person was continuously covered under the immediately preceding~~
37 ~~health plan. If the person was continuously covered for at least nine~~
38 ~~months under the immediately preceding health plan, the carrier may not~~

1 ~~impose a waiting period for coverage of preexisting conditions. If the~~
2 ~~person was continuously covered for less than nine months under the~~
3 ~~immediately preceding health plan, the carrier must credit any waiting~~
4 ~~period under the immediately preceding health plan toward the new~~
5 ~~health plan. For the purposes of this subsection, a preceding health~~
6 ~~plan includes an employer-provided self-funded health plan and plans of~~
7 ~~the Washington state health insurance pool.~~

8 (3)) For a health benefit plan offered to a group, every health
9 carrier shall reduce any preexisting condition exclusion, limitation,
10 or waiting period in the group health plan in accordance with the
11 provisions of section 2701 of the federal health insurance portability
12 and accountability act of 1996 (42 U.S.C. Sec. 300gg).

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

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

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

28 (c) For the purposes of this subsection, a preceding health plan
29 includes an employer-provided self-funded health plan and plans of the
30 Washington state health insurance pool.

31 (3) For a health benefit plan offered to a small group:

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

38 (b) If the individual applicant's immediately preceding health plan
39 coverage terminated during the period beginning ninety days and ending

1 sixty-four days before the date of application for the new plan and
2 such coverage was similar and continuous for less than nine months,
3 then the carrier shall credit the time covered under the immediately
4 preceding health plan toward any preexisting condition waiting period
5 under the new health plan.

6 (c) For the purpose of this subsection, a preceding health plan
7 includes an employer-provided self-funded health plan and plans of the
8 Washington state health insurance pool.

9 (4) For a health benefit plan offered to an individual, other than
10 an individual to whom subsection ((+4)) (5) of this section applies,
11 every health carrier shall credit any preexisting condition waiting
12 period in that plan for a person who was enrolled at any time during
13 the sixty-three day period immediately preceding the date of
14 application for the new health plan in a group health benefit plan or
15 an individual health benefit plan, other than a catastrophic health
16 plan, and (a) the benefits under the previous plan provide equivalent
17 or greater overall benefit coverage than that provided in the health
18 benefit plan the individual seeks to purchase; or (b) the person is
19 seeking an individual health benefit plan due to his or her change of
20 residence from one geographic area in Washington state to another
21 geographic area in Washington state where his or her current health
22 plan is not offered, if application for coverage is made within ninety
23 days of relocation; or (c) the person is seeking an individual health
24 benefit plan: (i) Because a health care provider with whom he or she
25 has an established care relationship and from whom he or she has
26 received treatment within the past twelve months is no longer part of
27 the carrier's provider network under his or her existing Washington
28 individual health benefit plan; and (ii) his or her health care
29 provider is part of another carrier's provider network; and (iii)
30 application for a health benefit plan under that carrier's provider
31 network individual coverage is made within ninety days of his or her
32 provider leaving the previous carrier's provider network. The carrier
33 must credit the period of coverage the person was continuously covered
34 under the immediately preceding health plan toward the waiting period
35 of the new health plan. For the purposes of this subsection ((+3))
36 (4), a preceding health plan includes an employer-provided self-funded
37 health plan and plans of the Washington state health insurance pool.

38 ((+4)) (5) Every health carrier shall waive any preexisting
39 condition waiting period in its individual plans for a person who is an

1 eligible individual as defined in section 2741(b) of the federal health
2 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
3 300gg-41(b)).

4 ~~((+5+))~~ (6) Subject to the provisions of subsections (1) through
5 ~~((+4+))~~ (5) of this section, nothing contained in this section requires
6 a health carrier to amend a health plan to provide new benefits in its
7 existing health plans. In addition, nothing in this section requires
8 a carrier to waive benefit limitations not related to an individual or
9 group's preexisting conditions or health history.

10 **Sec. 8.** RCW 48.43.018 and 2000 c 80 s 4 are each amended to read
11 as follows:

12 (1) Except as provided in (a) through (c) of this subsection, a
13 health carrier may require any person applying for an individual health
14 benefit plan to complete the standard health questionnaire designated
15 under chapter 48.41 RCW.

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

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

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

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

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

35 (c) If a person is seeking an individual health benefit plan due to
36 his or her having exhausted continuation coverage provided under 29
37 U.S.C. Sec. 1161 et seq., completion of the standard health
38 questionnaire shall not be a condition of coverage if application for

1 coverage is made within ninety days of exhaustion of continuation
2 coverage. A health carrier shall accept an application without a
3 standard health questionnaire from a person currently covered by such
4 continuation coverage if application is made within ninety days prior
5 to the date the continuation coverage would be exhausted and the
6 effective date of the individual coverage applied for is the date the
7 continuation coverage would be exhausted, or within ninety days
8 thereafter.

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

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

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

24 (3) If the person applying for an individual health benefit plan:

25 (a) Does not qualify for coverage under the Washington state health
26 insurance pool based upon the results of the standard health
27 questionnaire; (b) does qualify for coverage under the Washington state
28 health insurance pool based upon the results of the standard health
29 questionnaire and the carrier elects to accept the person for
30 enrollment; or (c) is not required to complete the standard health
31 questionnaire designated under this chapter under subsection (1)(a) or
32 (b) of this section, the carrier shall accept the person for enrollment
33 if he or she resides within the carrier's service area and provide or
34 assure the provision of all covered services regardless of age, sex,
35 family structure, ethnicity, race, health condition, geographic
36 location, employment status, socioeconomic status, other condition or
37 situation, or the provisions of RCW 49.60.174(2). The commissioner may
38 grant a temporary exemption from this subsection if, upon application
39 by a health carrier, the commissioner finds that the clinical,

1 financial, or administrative capacity to serve existing enrollees will
2 be impaired if a health carrier is required to continue enrollment of
3 additional eligible individuals.

4 **Sec. 9.** RCW 48.43.025 and 2000 c 79 s 23 are each amended to read
5 as follows:

6 (1) For group health benefit plans for groups other than small
7 groups, no carrier may reject an individual for health plan coverage
8 based upon preexisting conditions of the individual and no carrier may
9 deny, exclude, or otherwise limit coverage for an individual's
10 preexisting health conditions; except that a carrier may impose a
11 three-month benefit waiting period for preexisting conditions for which
12 medical advice was given, or for which a health care provider
13 recommended or provided treatment(~~(, or for which a prudent layperson~~
14 ~~would have sought advice or treatment,)~~) within three months before the
15 effective date of coverage. Any preexisting condition waiting period
16 or limitation relating to pregnancy as a preexisting condition shall be
17 imposed only to the extent allowed in the federal health insurance
18 portability and accountability act of 1996.

19 (2) For group health benefit plans for small groups, no carrier may
20 reject an individual for health plan coverage based upon preexisting
21 conditions of the individual and no carrier may deny, exclude, or
22 otherwise limit coverage for an individual's preexisting health
23 conditions. Except that a carrier may impose a nine-month benefit
24 waiting period for preexisting conditions for which medical advice was
25 given, or for which a health care provider recommended or provided
26 treatment(~~(, or for which a prudent layperson would have sought advice~~
27 ~~or treatment,)~~) within six months before the effective date of
28 coverage. Any preexisting condition waiting period or limitation
29 relating to pregnancy as a preexisting condition shall be imposed only
30 to the extent allowed in the federal health insurance portability and
31 accountability act of 1996.

32 (3) No carrier may avoid the requirements of this section through
33 the creation of a new rate classification or the modification of an
34 existing rate classification. A new or changed rate classification
35 will be deemed an attempt to avoid the provisions of this section if
36 the new or changed classification would substantially discourage
37 applications for coverage from individuals or groups who are higher

1 than average health risks. These provisions apply only to individuals
2 who are Washington residents.

3 NEW SECTION. **Sec. 10.** A new section is added to chapter 48.43 RCW
4 to read as follows:

5 To the extent required of the federal health insurance portability
6 and accountability act of 1996, the eligibility of an employer or group
7 to purchase a health benefit plan set forth in RCW 48.21.045(1)(b),
8 48.44.023(1)(b), and 48.46.066(1)(b) must be extended to all small
9 employers and small groups as defined in RCW 48.43.005.

10 **Sec. 11.** RCW 48.44.017 and 2000 c 79 s 29 are each amended to read
11 as follows:

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

14 (a) "Claims" means the cost to the health care service contractor
15 of health care services, as defined in RCW 48.43.005, provided to a
16 contract holder or paid to or on behalf of a contract holder in
17 accordance with the terms of a health benefit plan, as defined in RCW
18 48.43.005. This includes capitation payments or other similar payments
19 made to providers for the purpose of paying for health care services
20 for an enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

23 (5) By the last day of May each year any health care service
24 contractor (~~(providing)~~) issuing or renewing individual health benefit
25 plans in this state during the preceding calendar year shall file for
26 review by the commissioner supporting documentation of its actual loss
27 ratio for its individual health benefit plans offered or renewed in
28 this state in aggregate for the preceding calendar year. The filing
29 shall include aggregate earned premiums, aggregate incurred claims, and
30 a certification by a member of the American academy of actuaries, or
31 other person approved by the commissioner, that the actual loss ratio
32 has been calculated in accordance with accepted actuarial principles.

33 (a) At the expiration of a thirty-day period beginning with the
34 date the filing is (~~delivered to~~) received by the commissioner, the
35 filing shall be deemed approved unless prior thereto the commissioner
36 contests the calculation of the actual loss ratio.

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

1 (c) Any dispute regarding the calculation of the actual loss ratio
2 shall upon written demand of either the commissioner or the health care
3 service contractor be submitted to hearing under chapters 48.04 and
4 34.05 RCW.

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

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

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

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

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

25 (7) The loss ratio applicable to this section shall be seventy-four
26 percent minus the premium tax rate applicable to the health care
27 service contractor's individual health benefit plans under RCW
28 48.14.0201.

29 **Sec. 12.** RCW 48.46.062 and 2000 c 79 s 32 are each amended to read
30 as follows:

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

33 (a) "Claims" means the cost to the health maintenance organization
34 of health care services, as defined in RCW 48.43.005, provided to an
35 enrollee or paid to or on behalf of the enrollee in accordance with the
36 terms of a health benefit plan, as defined in RCW 48.43.005. This
37 includes capitation payments or other similar payments made to

1 providers for the purpose of paying for health care services for an
2 enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

3 (5) By the last day of May each year any health maintenance
4 organization (~~(providing)~~) issuing or renewing individual health
5 benefit plans in this state during the preceding calendar year shall
6 file for review by the commissioner supporting documentation of its
7 actual loss ratio for its individual health benefit plans offered or
8 renewed in the state in aggregate for the preceding calendar year. The
9 filing shall include aggregate earned premiums, aggregate incurred
10 claims, and a certification by a member of the American academy of
11 actuaries, or other person approved by the commissioner, that the
12 actual loss ratio has been calculated in accordance with accepted
13 actuarial principles.

14 (a) At the expiration of a thirty-day period beginning with the
15 date the filing is (~~(delivered to)~~) received by the commissioner, the
16 filing shall be deemed approved unless prior thereto the commissioner
17 contests the calculation of the actual loss ratio.

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

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

25 (6) If the actual loss ratio for the preceding calendar year is
26 less than the loss ratio standard established in subsection (7) of this
27 section, a remittance is due and the following shall apply:

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

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

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

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

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

11 **Sec. 13.** RCW 70.47.060 and 2000 c 79 s 34 are each amended to read
12 as follows:

13 The administrator has the following powers and duties:

14 (1) To design and from time to time revise a schedule of covered
15 basic health care services, including physician services, inpatient and
16 outpatient hospital services, prescription drugs and medications, and
17 other services that may be necessary for basic health care. In
18 addition, the administrator may, to the extent that funds are
19 available, offer as basic health plan services chemical dependency
20 services, mental health services and organ transplant services;
21 however, no one service or any combination of these three services
22 shall increase the actuarial value of the basic health plan benefits by
23 more than five percent excluding inflation, as determined by the office
24 of financial management. All subsidized and nonsubsidized enrollees in
25 any participating managed health care system under the Washington basic
26 health plan shall be entitled to receive covered basic health care
27 services in return for premium payments to the plan. The schedule of
28 services shall emphasize proven preventive and primary health care and
29 shall include all services necessary for prenatal, postnatal, and well-
30 child care. However, with respect to coverage for subsidized enrollees
31 who are eligible to receive prenatal and postnatal services through the
32 medical assistance program under chapter 74.09 RCW, the administrator
33 shall not contract for such services except to the extent that such
34 services are necessary over not more than a one-month period in order
35 to maintain continuity of care after diagnosis of pregnancy by the
36 managed care provider. The schedule of services shall also include a
37 separate schedule of basic health care services for children, eighteen
38 years of age and younger, for those subsidized or nonsubsidized

1 enrollees who choose to secure basic coverage through the plan only for
2 their dependent children. In designing and revising the schedule of
3 services, the administrator shall consider the guidelines for assessing
4 health services under the mandated benefits act of 1984, RCW 48.47.030,
5 and such other factors as the administrator deems appropriate.

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

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

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

27 (d) To develop, as an offering by every health carrier providing
28 coverage identical to the basic health plan, as configured on January
29 1, 2001, a basic health plan model plan with uniformity in enrollee
30 cost-sharing requirements.

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

38 (4) To limit enrollment of persons who qualify for subsidies so as
39 to prevent an overexpenditure of appropriations for such purposes.

1 Whenever the administrator finds that there is danger of such an
2 overexpenditure, the administrator shall close enrollment until the
3 administrator finds the danger no longer exists.

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

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

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

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

36 (9) To accept applications from individuals residing in areas
37 served by the plan, on behalf of themselves and their spouses and
38 dependent children, for enrollment in the Washington basic health plan
39 as subsidized or nonsubsidized enrollees, to establish appropriate

1 minimum-enrollment periods for enrollees as may be necessary, and to
2 determine, upon application and on a reasonable schedule defined by the
3 authority, or at the request of any enrollee, eligibility due to
4 current gross family income for sliding scale premiums. Funds received
5 by a family as part of participation in the adoption support program
6 authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall
7 not be counted toward a family's current gross family income for the
8 purposes of this chapter. When an enrollee fails to report income or
9 income changes accurately, the administrator shall have the authority
10 either to bill the enrollee for the amounts overpaid by the state or to
11 impose civil penalties of up to two hundred percent of the amount of
12 subsidy overpaid due to the enrollee incorrectly reporting income. The
13 administrator shall adopt rules to define the appropriate application
14 of these sanctions and the processes to implement the sanctions
15 provided in this subsection, within available resources. No subsidy
16 may be paid with respect to any enrollee whose current gross family
17 income exceeds twice the federal poverty level or, subject to RCW
18 70.47.110, who is a recipient of medical assistance or medical care
19 services under chapter 74.09 RCW. If a number of enrollees drop their
20 enrollment for no apparent good cause, the administrator may establish
21 appropriate rules or requirements that are applicable to such
22 individuals before they will be allowed to reenroll in the plan.

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

1 managed health care system or systems is modified or the administrative
2 cost of providing the plan to such enrollees changes.

3 (11) To determine the rate to be paid to each participating managed
4 health care system in return for the provision of covered basic health
5 care services to enrollees in the system. Although the schedule of
6 covered basic health care services will be the same or actuarially
7 equivalent for similar enrollees, the rates negotiated with
8 participating managed health care systems may vary among the systems.
9 In negotiating rates with participating systems, the administrator
10 shall consider the characteristics of the populations served by the
11 respective systems, economic circumstances of the local area, the need
12 to conserve the resources of the basic health plan trust account, and
13 other factors the administrator finds relevant.

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

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

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

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

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

1 (17) To administer the premium discounts provided under RCW
2 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington
3 state health insurance pool.

4 NEW SECTION. **Sec. 14.** This act is necessary for the immediate
5 preservation of the public peace, health, or safety, or support of the
6 state government and its existing public institutions, and takes effect
7 immediately.

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