S-1210.1

SENATE BILL 5888

State of Washington 59th Legislature 2005 Regular Session

By Senators Thibaudeau, Franklin, Poulsen and Kline

Read first time 02/11/2005. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to access to individual health insurance coverage; amending RCW 42.30.020, 48.18.110, 48.20.025, 48.41.030, 48.41.037, 48.41.040, 48.41.060, 48.41.080, 48.41.090, 48.41.100, 48.41.110, 48.41.120, 48.41.140, 48.41.160, 48.41.190, 48.41.200, 48.44.017, 48.44.020, 48.46.060, 48.46.062, and 70.47.060; reenacting and amending RCW 48.04.010; and providing an effective date.

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

Sec. 1. RCW 42.30.020 and 1985 c 366 s 1 are each amended to read as follows:

As used in this chapter unless the context indicates otherwise:

(1) "Public agency" means:

(a) Any state board, commission, committee, department, educational institution, or other state agency<u>, including the Washington state health insurance pool established in chapter 48.41 RCW,</u> which is created by or pursuant to statute, other than courts and the legislature;

(b) Any county, city, school district, special purpose district, or other municipal corporation or political subdivision of the state of Washington;

(c) Any subagency of a public agency which is created by or pursuant to statute, ordinance, or other legislative act, including but not limited to planning commissions, library or park boards, commissions, and agencies;

(d) Any policy group whose membership includes representatives of publicly owned utilities formed by or pursuant to the laws of this state when meeting together as or on behalf of participants who have contracted for the output of generating plants being planned or built by an operating agency.

(2) "Governing body" means the multimember board, commission, committee, council, or other policy or rule-making body of a public agency, or any committee thereof when the committee acts on behalf of the governing body, conducts hearings, or takes testimony or public comment.

(3) "Action" means the transaction of the official business of a public agency by a governing body including but not limited to receipt of public testimony, deliberations, discussions, considerations, reviews, evaluations, and final actions. "Final action" means a collective positive or negative decision, or an actual vote by a majority of the members of a governing body when sitting as a body or entity, upon a motion, proposal, resolution, order, or ordinance.

(4) "Meeting" means meetings at which action is taken.

Sec. 2. RCW 48.04.010 and 2000 c 221 s 8 and 2000 c 79 s 1 are each reenacted and 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) Except under RCW 48.13.475, upon written demand for a hearing made by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an act under any provision of this code, or by any report, promulgation, or order of the commissioner other than an order on a hearing of which such person was given actual notice or at which such person appeared as a party, or order pursuant to the order on such hearing.

(2) Any such demand for a hearing shall specify in what respects

such person is so aggrieved and the grounds to be relied upon as basis for the relief to be demanded at the hearing.

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

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

((~~(5) A licensee under this title may request that a hearing authorized under this section be presided over by an administrative law judge assigned under chapter 34.12 RCW. Any such request shall not be denied.~~

~~(6) Any hearing held relating to RCW 48.20.025, 48.44.017, or 48.46.062 shall be presided over by an administrative law judge assigned under chapter 34.12 RCW.~~))

Sec. 3. RCW 48.18.110 and 2000 c 79 s 2 are each amended to read as follows:

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

((~~(a)~~)) (1) If it is in any respect in violation of or does not comply with this code or any applicable order or regulation of the commissioner issued pursuant to the code; or

((~~(b)~~)) (2) If it does not comply with any controlling filing theretofore made and approved; or

((~~(c)~~)) (3) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; or

((~~(d)~~)) (4) If it has any title, heading, or other indication of its provisions which is misleading; or

((~~(e)~~)) (5) If purchase of insurance thereunder is being solicited by deceptive advertising((~~.~~

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

(6) If the benefits provided therein are unreasonable in relation to the premium charged.

Sec. 4. RCW 48.20.025 and 2003 c 248 s 8 are each amended to read as follows:

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

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

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

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

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

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

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

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

(3) An insurer shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request ((~~only the following~~)) supporting documentation, including but not limited to:

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

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

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

(d) A certification by ((~~a~~)) an independent member of the American academy of actuaries, or other person approved by 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)~~)) (6) of this section.

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

~~(5)~~)) By the last day of May each year any insurer issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in the state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by ((~~a~~)) an independent member of the American academy of actuaries, or other person approved by 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 beginning with the date the filing is received by 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 insurer.

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

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

(a) The insurer shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection ((~~(7)~~)) (6) of this section.

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

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used ((~~as directed by the pool board of directors~~)) solely to fund the rate discounts provided under RCW 48.41.200.

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

((~~(7)~~)) (6) The loss ratio applicable to this section shall be ((~~seventy-four~~)) eighty-three percent minus the premium tax rate applicable to the insurer's individual health benefit plans under RCW 48.14.020.

Sec. 5. RCW 48.41.030 and 2004 c 260 s 25 are each amended to read as follows:

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, <u>including medicare supplemental policies,</u> 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, 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.

(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 (10) of this section.

(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.

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

(14) "Member" means any commercial insurer which provides disability insurance or stop loss insurance, any health care service contractor, any health maintenance organization licensed under Title 48 RCW, and any self-funded multiple employer welfare arrangement as defined in RCW 48.125.010. "Member" also means the Washington state health care authority as issuer of the state uniform medical plan. "Member" shall also mean, ((~~as soon as~~)) to the extent 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 (10) of this section.

(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.

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

(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.

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

Sec. 6. RCW 48.41.037 and 2000 c 79 s 36 are each amended 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 this account shall be used 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 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~~)) one dollar and fifty cents per insured person per month for the calendar year 2005, and indexed annually thereafter to the rate of medical inflation as determined by the office of financial management. The commissioner shall authorize expenditures from the account, to the extent that funds are available in the account, upon actuarial certification to the commissioner by the pool board that assessments ((~~will~~)) for the current calendar year are expected to exceed the threshold level established in this section. The certification shall be sent to the commissioner no later than September 30th of each year. The account is subject to the allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

Sec. 7. RCW 48.41.040 and 2000 c 80 s 1 are each amended to read as follows:

(1) There is 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 ten members. The governor shall select one member of the board from each list of three nominees submitted by statewide organizations representing each of the following: (a) Health care providers; (b) health insurance agents; (c) small employers; and (d) large employers. The governor shall select ((~~two~~)) three members of the board from a list of nominees submitted by statewide organizations representing health care consumers. In making these selections, the governor may request additional names from the statewide organizations representing each of the persons to be selected if the governor chooses not to select a member from the list submitted. The remaining ((~~four~~)) three members of the board shall be selected by election from among the members of the pool. The elected members shall, to the extent possible, 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 members of the board shall elect a chair from the voting members of the board. The insurance commissioner shall be a nonvoting, ex officio member. When self-insured organizations other than the Washington state health care authority 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.

(3) The original members of the board of directors shall be appointed for intervals of one to three years. Thereafter, all board members shall serve a term of three years. 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.

Sec. 8. RCW 48.41.060 and 2004 c 260 s 26 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 shall:

(a) Designate or establish the standard health questionnaire to be used under RCW 48.41.100 and 48.43.018, including the form and content of the standard health questionnaire and the method of its application. The questionnaire must provide for an objective evaluation of an individual's health status by assigning a discreet measure, such as a system of point scoring to each individual. The questionnaire must not contain any questions related to pregnancy, and pregnancy shall not be a basis for coverage by the pool. The questionnaire shall be designed such that it is reasonably expected to identify the ((~~eight~~)) five percent of persons who are the most costly to treat who are under individual coverage in health benefit plans, as defined in RCW 48.43.005, in Washington state or are covered by the pool, if applied to all such persons;

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

(c) Approve the standard health questionnaire and any modifications needed to comply with this chapter. The standard health questionnaire shall be submitted to an actuary for certification, modified as

necessary, and approved at least every eighteen months. The designation and approval of the standard health questionnaire by the board shall ((~~not~~)) be subject to review and approval by the commissioner. The standard health questionnaire or any modification thereto shall not be used until ninety days after public notice of the commissioner's approval of the questionnaire or any modification thereto, except that the initial standard health questionnaire approved for use by the board after March 23, 2000, may be used immediately following public notice of such approval;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, 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 individual plan rating requirements under RCW 48.44.022 and 48.46.064;

(e) Assess members of the pool in accordance with the provisions of this chapter, and make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year. Self-funded multiple employer welfare arrangements are subject to assessment under this subsection only in the event that assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing assessments on these arrangements before imposing the assessment. If there has not been a final determination by the United States department of labor or a federal court that the assessments are not preempted by federal law, the assessments provided for in this subsection become effective on March 1, 2005, or thirty days following the issuance of a certificate of authority, whichever is later. During the time period between March 1, 2005, or thirty days following the issuance of a certificate of authority, whichever is

later, and the final determination by the United States department of labor or a federal court, any assessments shall be deposited in an interest bearing escrow account maintained by the ((~~[self-funded]~~)) self-funded multiple employer welfare arrangement. Upon a final determination that the assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the board;

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

(g) Establish procedures for the administration of the premium discount provided under RCW 48.41.200(3)(a)(iii);

(h) Contract with the ((~~Washington state health care authority~~)) pool administrator for the administration of the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii);

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

(j) Provide certification to the commissioner when assessments will exceed the threshold level established in RCW 48.41.037;

(k) Contract with an independent certified public accountant for an annual audit of pool operations;

(l) Conduct, at least once every eighteen months, a statistically valid survey of pool enrollees to determine their satisfaction with coverage, rates, administration, and other customer service issues, and report the results of the survey to the commissioner upon its completion; and

(m) Conduct, at least once every eighteen months, a statistically valid survey of individual market applicants who, through the use of the standard health questionnaire, were referred to the pool by carriers, with the intention to discern demographic information including but not limited to the current coverage status of the surveyed applicants whether or not they enrolled in a pool plan; their understanding of the standard health questionnaire, its clarity and ease of use; and their opinions regarding plan choices, premiums, and barriers to entry into the pool. Results of the survey shall be reported to the commissioner upon its completion.

(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

(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~~)).

(3) Nothing in this section shall be construed to require or authorize the adoption of rules under chapter 34.05 RCW.

Sec. 9. RCW 48.41.080 and 2000 c 79 s 10 are each amended to read as follows:

The board shall select an administrator 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 <u>by the pool board</u>. 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) Administering eligibility and administrative claim payment functions relating to the pool;

(b) 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) 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) 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) 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; and

(f) Administering the premium discounts provided under RCW 48.41.200.

(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. 10. RCW 48.41.090 and 2000 c 79 s 11 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 the fraction equals that member's total number of resident insured persons, including spouse and dependents, covered under all health plans in the state by that member during the preceding calendar year. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, covered under all health plans in the state by all pool members during the preceding calendar year.

(b) For purposes of calculating the numerator and the denominator under (a) of this subsection((~~:~~

~~(i)~~)), all health plans in the state by the state health care authority include only the uniform medical plan((~~; and~~

~~(ii) Each ten resident insured persons, including spouse and dependents, under a stop loss plan or the uniform medical plan shall count as one resident insured person~~)).

(c) Except as provided in RCW 48.41.037, 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.

(5) A member's payment of the assessment shall not be the basis for an exemption or deduction from any state taxes or fees.

Sec. 11. RCW 48.41.100 and 2001 c 196 s 3 are each amended to read as follows:

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

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

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

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

(d) Any medicare eligible person upon providing evidence of rejection for medical reasons for any policy for which he or she has applied, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on a medicare supplemental insurance policy under chapter 48.66 RCW, 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; and

(e) Any person whom the United States social security administration determines to be disabled.

(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. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

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

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

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

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

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

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

Sec. 12. RCW 48.41.110 and 2001 c 196 s 4 are each amended to read as follows:

(1) The pool shall offer one or more 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, 2001, may continue coverage under the pool plan in which they are enrolled on that date. However, the pool may incorporate managed care features into such existing plans.

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

(3) The health insurance policy issued by the pool shall pay only reasonable 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 reasonable 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~~)) Inpatient and 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;

(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.

(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.

(5) The pool benefit ((~~policy~~)) policies may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with group 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~~)) policies 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.

(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 shall impose a ((~~six~~)) three-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services or for the formula necessary for the treatment of phenylketonuria. 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 as provided in subsection (7) of this section.

(7)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool 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.

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

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

Sec. 13. RCW 48.41.120 and 2000 c 79 s 14 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 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. 14. RCW 48.41.140 and 2000 c 79 s 16 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~~)) disorders 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 policyholder 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.

Sec. 15. RCW 48.41.160 and 1987 c 431 s 16 are each amended to read as follows:

(1) A pool policy offered under this chapter shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150.

(2) The pool may not change the rates for pool policies except on a class basis, with a clear disclosure in the policy of the pool's right to do so.

(3) A pool policy offered under this chapter shall provide that, upon the death of the individual in whose name the policy is issued, every other individual then covered under the policy may elect, within a period specified in the policy, to continue coverage under the same or a different policy.

(4) At least once a year, the pool must provide the opportunity for any person covered by a pool policy, other than the medicare supplemental policy, to change coverage to any other pool policy, other than the medicare supplemental policy.

Sec. 16. RCW 48.41.190 and 1989 c 121 s 10 are each amended to read as follows:

((~~Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal liability or penalty against the pool, any member of the board of directors, or members of the pool either jointly or separately.~~)) The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken, including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter.

Sec. 17. RCW 48.41.200 and 2000 c 79 s 17 are each amended to read as follows:

(1) The pool shall determine the standard risk rate by calculating the average individual standard rate charged for coverage comparable to pool coverage by the five largest members, measured in terms of average individual market enrollment during the previous two calendar years, offering such coverages in the state. 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 where it is currently available in the individual market.

(2) Subject to subsection (3) of this section, maximum rates for pool coverage shall be as follows:

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

(c) Maximum rates for a person under age sixty-five covered by the pool medicare supplemental policy shall be one hundred ten percent of the rate calculated under subsection (1) of this section; and

(d) Maximum rates for a person eligible for pool coverage pursuant to RCW 48.41.100(1)(a) who was enrolled at any time during the sixty-three day period immediately prior to the date of application for pool coverage in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005, where such coverage was continuous for at least eighteen months, shall be:

(i) For a pool indemnity health plan, one hundred twenty-five percent of the rate calculated under subsection (1) of this section; and

(ii) For a pool care management plan, one hundred ten percent of the rate calculated under subsection (1) of this section.

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

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

(ii) The rate for any person ((~~aged fifty to sixty-four~~)) 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, except those eligible for a rate reduction under (a)(i) of this subsection, be less than one hundred ten percent of the rate calculated under subsection (1) of this section.

(c) Rate reductions under (a)(i) and (ii) of this subsection shall be available only to the extent that funds are specifically appropriated for this purpose in the omnibus appropriations act or to the extent funds are available from remittance due under RCW 48.20.025(5)(c), 48.44.017(5)(c), or 48.46.062(5)(c).

Sec. 18. RCW 48.44.017 and 2001 c 196 s 11 are each amended to read as follows:

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

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

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

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

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

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

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

(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<u>, including but not limited to</u>:

(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~~)) an independent member of the American academy of actuaries, or other person approved by 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)~~)) (6) 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 issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for its individual health benefit plans offered or renewed in this state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and ((~~a~~)) an independent certification by a member of the American academy of actuaries, or other person approved by 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 beginning with the date the filing is received by 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)~~)) (5) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection ((~~(7)~~)) (6) of this section, a remittance is due and the following shall apply:

(a) The health care service contractor shall calculate a percentage of premium to be remitted to the Washington state health insurance pool

by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection ((~~(7)~~)) (6) of this section.

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

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used ((~~as directed by the pool board of directors~~)) solely to fund the rate discounts provided under RCW 48.41.200.

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

((~~(7)~~)) (6) The loss ratio applicable to this section shall be ((~~seventy-four~~)) eighty-three percent minus the premium tax rate applicable to the health care service contractor's individual health benefit plans under RCW 48.14.0201.

Sec. 19. RCW 48.44.020 and 2000 c 79 s 28 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 it contains unreasonable restrictions on the treatment of patients; or

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

(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

(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~~)); or

(h) If the benefits provided therein are unreasonable in relation to the amount charged for the contract.

((~~(4)~~)) (3)(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.

Sec. 20. RCW 48.46.060 and 2000 c 79 s 31 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 it contains unreasonable restrictions on the treatment of patients;

(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

(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~~));

(g) If the benefits provided therein are unreasonable in relation to the amount charged for the agreement.

((~~(5)~~)) (4) 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. 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.

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

Sec. 21. RCW 48.46.062 and 2001 c 196 s 12 are each amended to read as follows:

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

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

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

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

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

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

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

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

(3) A health maintenance organization shall file with the notice required under subsection (2) of this section supporting documentation of its method of determining the rates charged. The commissioner may request ((~~only the following~~)) supporting documentation, including but not limited to:

(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~~)) an independent member of the American academy of actuaries, or other person approved by 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)~~)) (6) 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 issuing or renewing individual health benefit plans in this state during the preceding calendar year shall file for review by the commissioner supporting documentation of its actual loss ratio for

its individual health benefit plans offered or renewed in the state in aggregate for the preceding calendar year. The filing shall include aggregate earned premiums, aggregate incurred claims, and a certification by a member of the American academy of actuaries, or other person approved by 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 beginning with the date the filing is received by 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)~~)) (5) If the actual loss ratio for the preceding calendar year is less than the loss ratio standard established in subsection ((~~(7)~~)) (6) of this section, a remittance is due and the following shall apply:

(a) The health maintenance organization shall calculate a percentage of premium to be remitted to the Washington state health insurance pool by subtracting the actual loss ratio for the preceding year from the loss ratio established in subsection ((~~(7)~~)) (6) of this section.

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

(c) All remittances shall be aggregated and such amounts shall be remitted to the Washington state high risk pool to be used ((~~as directed by the pool board of directors~~)) solely to fund the rate discounts provided under RCW 48.41.200.

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

approved under subsection ((~~(5)~~)) (4)(a) of this section or the determination by an administrative law judge under subsection ((~~(5)~~)) (4)(c) of this section.

((~~(7)~~)) (6) The loss ratio applicable to this section shall be ((~~seventy-four~~)) eighty-three percent minus the premium tax rate applicable to the health maintenance organization's individual health benefit plans under RCW 48.14.0201.

Sec. 22. RCW 70.47.060 and 2004 c 192 s 3 are each 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 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.

(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 (11) 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 (12) 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) To determine the periodic premiums due the administrator from health coverage tax credit eligible enrollees. Premiums due from health coverage tax credit eligible enrollees must 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. The administrator will consider the impact of eligibility determination by the appropriate federal agency designated by the Trade Act of 2002 (P.L. 107-210) as well as the premium collection and remittance activities by the United States internal revenue service when determining the administrative cost charged for health coverage tax credit eligible enrollees.

(d) 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. The administrator shall establish a mechanism for receiving premium payments from the United States internal revenue service for health coverage tax credit eligible enrollees.

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

(3) To evaluate, with the cooperation of participating managed health care system providers, the impact on the basic health plan of enrolling health coverage tax credit eligible enrollees. The administrator shall issue to the appropriate committees of the legislature preliminary evaluations on June 1, 2005, and January 1, 2006, and a final evaluation by June 1, 2006. The evaluation shall address the number of persons enrolled, the duration of their enrollment, their utilization of covered services relative to other basic health plan enrollees, and the extent to which their enrollment contributed to any change in the cost of the basic health plan.

(4) To end the participation of health coverage tax credit eligible enrollees in the basic health plan if the federal government reduces or terminates premium payments on their behalf through the United States internal revenue service.

(5) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, nonsubsidized, and health coverage tax credit eligible 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.

(6) 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. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

(7) 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.

(8) 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.

(9) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan for subsidized enrollees, nonsubsidized enrollees, or health coverage tax credit eligible enrollees. 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.

(10) To receive periodic premiums from or on behalf of subsidized, nonsubsidized, and health coverage tax credit eligible 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.

(11) 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, nonsubsidized, or health coverage tax credit eligible 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.

(12) 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.

(13) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of

covered basic health care services will be the same or actuarially equivalent 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.

(14) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the 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.

(15) 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.

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

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

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

((~~(19) To administer the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington~~

~~state health insurance pool.~~))

NEW SECTION. **Sec. 23.** This act takes effect January 1, 2006.

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