H-2772.1

SECOND SUBSTITUTE HOUSE BILL 1569

State of Washington 60th Legislature 2007 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Cody, Campbell, Morrell, Linville, Moeller, Green, Seaquist, Conway, Dickerson, Appleton, McIntire, McCoy, Kagi, Pedersen, Kenney, Lantz, Santos, Wood and Ormsby)

READ FIRST TIME 03/05/07.

AN ACT Relating to reforming the health care system in Washington state; amending RCW 48.43.005, 48.43.015, 48.43.025, 48.43.035, 48.21.047, 48.44.024, 48.46.068, and 48.43.028; adding new sections to chapter 48.43 RCW; adding a new chapter to Title 41 RCW; adding a new chapter to Title 49 RCW; creating new sections; repealing RCW 48.21.045, 48.44.023, 48.46.066, 70.47A.010, 70.47A.020, 70.47A.030, 70.47A.040, 70.47A.050, 70.47A.060, 70.47A.070, 70.47A.080, 70.47A.090, and 70.47A.900; and providing effective dates.

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

PART I: FINDINGS AND INTENT

NEW SECTION. **Sec. 101.** LEGISLATIVE FINDINGS. The legislature finds that:

(1) The people of Washington have expressed strong concerns about health care costs and access to needed health services. Even if currently insured, they are not confident that they will continue to have health insurance coverage in the future and feel that they are getting less, but spending more.

(2) Many employers, especially small employers, struggle with the cost of providing employer-sponsored health insurance coverage to their employees, while others are unable to offer employer-sponsored health insurance due to its high cost.

(3) Six hundred thousand Washingtonians are uninsured. Three-quarters work or have a working family member; two-thirds have incomes below two hundred percent of the federal poverty level; and one-half are young adults age nineteen to thirty-four. Many are low-wage workers who are not offered, or eligible for, employer-sponsored coverage. Others struggle to pay their share of the costs of employer-sponsored health insurance, while still others turn down their employer's offer of coverage due to its costs. By failing to make health insurance coverage affordable for low-wage workers and self-employed people, health problems that could be treated in a doctor's office are treated in the emergency room or hospital.

(4) The workforce in Washington state has undergone many changes in the last three decades. Employment has shifted from manufacturing to service-providing industries, a rising share of workers are employed by small employers, and a growing number of people are self-employed, temporary or contract workers, or work for multiple employers.

(5) Access to health insurance and other health care spending has resulted in improved health for many Washingtonians. Yet, the Washington state blue ribbon commission on health care costs and access recently found that health purchasers and carriers should focus efforts on receiving more value for each health care dollar spent in Washington state through efforts such as paying for care that has proven value, focusing on prevention and management of chronic disease, and providing consumers incentives to use quality health care providers and systems.

NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT. The legislature intends, through the public/private partnership reflected in this act, to improve the current health care system so that:

(1) Health insurance coverage is more affordable for employers, employees, self-employed people, and other individuals;

(2) The process of choosing and purchasing health insurance coverage is well-informed, clearer, and simpler;

(3) Prevention, chronic care management, wellness, and improved

quality of care are integral and valued parts of the health insurance system; and

(4) As a result of these changes, more people in Washington state have access to affordable health insurance coverage and health outcomes in Washington state are improved.

PART II: WASHINGTON HEALTH INSURANCE PARTNERSHIP

NEW SECTION. **Sec. 201.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administrator" means the administrator of the health care authority as defined in RCW 41.05.011.

(2) "Authority" means the health care authority established in chapter 41.05 RCW.

(3) "Basic health plan" means the program administered under chapter 70.47 RCW.

(4) "Carrier" means a carrier as defined in RCW 48.43.005.

(5) "Commissioner" means the insurance commissioner established under RCW 48.02.010.

(6) "Health plan" or "health benefit plan" means a health plan or health benefit plan as defined in RCW 48.43.005.

(7) "Participating small employer plan" means a group health plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1167), that is sponsored by a small employer and for which the plan sponsor has entered into an agreement with the partnership, in accordance with this act, for the partnership to offer and administer health insurance benefits for enrollees in the plan.

(8) "Partnership" means the Washington health insurance partnership established in sections 202 and 203 of this act.

(9) "Partnership board" and "board" means the board of the Washington health insurance partnership established in section 204 of this act.

(10) "Partnership participant" means a person who has been determined by the Washington health insurance partnership to be, and continues to be, an employee of a participating small employer plan for purposes of obtaining coverage through the partnership, or a former employee of a participating small employer plan who chooses to continue

receiving coverage through the partnership following separation from employment.

(11) "Premium assistance payment" means a payment made to carriers by the partnership as provided in section 205 of this act.

(12) "Small group" or "small employer" means a small group or small employer as defined in RCW 48.43.005.

(13) "Successful bidder" means the entity that is chosen to operate the Washington health insurance partnership as a result of the procurement in sections 202 and 203 of this act.

NEW SECTION. **Sec. 202.** REQUEST FOR PROPOSAL TO OPERATE THE WASHINGTON HEALTH INSURANCE PARTNERSHIP. (1) On or before December 30, 2007, in consultation with and upon approval by the board established in section 204 of this act, the authority shall develop a request for proposal to establish and operate a Washington health insurance partnership. The partnership shall be designed to serve as a statewide, public-private partnership, offering maximum value for Washington state residents, through which small group health plans may be bought and sold. Private entities may respond to the request for proposal.

(2) It is the goal of the partnership to:

(a) Ensure that employees of small businesses and other individuals can find affordable health plans;

(b) Provide a mechanism for small businesses to contribute to their employees' coverage without the administrative burden of directly shopping or contracting for a health plan;

(c) Ensure that individuals can access coverage as they change and/or work in multiple jobs; and

(d) Provide a mechanism for low-income workers to obtain affordable coverage through competition among carriers in the partnership, and premium assistance payments as available.

(3) The health care authority shall submit a summary of the request for proposal and the report required by subsection (4) of this section to the governor and the appropriate committees of the senate and house of representatives on or before January 1, 2008. If the legislature does not take affirmative action to reject or modify the request for proposal during the 2008 regular legislative session, the administrator shall issue the request for proposal on April 1, 2008.

(4) The authority, in collaboration with the office of the insurance commissioner and the partnership board, upon appointment, shall analyze the following issues and provide a report and recommendations to the appropriate committees of the senate and house of representatives by January 1, 2008:

(a) The impact of applying small group health plan rating rules to a market in which each employee chooses their health plan;

(b) Options that reduce uncertainty for carriers and provide for efficient risk management of high-cost participants or small employer plans through risk adjustment, reinsurance, or any other effective mechanism; and

(c) Other issues identified by the partnership board as potential barriers to a successful transition of the small group market to the partnership.

NEW SECTION. **Sec. 203.** CONTENTS OF THE REQUEST FOR PROPOSAL. The request for proposal issued under section 202 of this act shall include:

(1) The appropriate qualifications for operation of the Washington health insurance partnership;

(2) Key functions of the partnership, including but not limited to:

(a) Offering choice among any small group health plan approved by the commissioner under Title 48 RCW. The choice of health plans shall include one or more limited health care service plans for dental care services to be offered by limited health care service contractors under RCW 48.44.035;

(b) Establishing enrollment procedures, including publicizing the existence of the partnership and disseminating information on enrollment, and establishing rules related to minimum participation of employees in small groups purchasing health insurance through the partnership;

(c) Establishing and administering procedures for the election of coverage by partnership participants during open enrollment periods and outside of open enrollment periods upon the occurrence of any qualifying event specified in the federal health insurance portability and accountability act of 1996 or applicable state law;

(d) Establishing and managing a system for the partnership to be designated as the sponsor or administrator of a participating small

employer plan and to undertake the obligations required of a plan administrator under federal law. The small employer shall determine the criteria for eligibility and enrollment in his or her plan and the terms and amounts of the employer's contributions to that plan. Neither the employer nor the partnership shall limit an employee's choice of coverage from among all the health plans offered;

(e) Establishing and managing a system of collecting and transmitting to the applicable carriers all premium payments or contributions made by or on behalf of partnership participants, including employer contributions, automatic payroll deductions for partnership participants enrolled in small employer plans, premium assistance payments under section 205 of this act, and contributions from philanthropies;

(f) Establishing and managing a system for determining eligibility for premium assistance payments and remitting premium assistance payments to the carriers, as provided in section 205 of this act;

(g) Assessing the need for mechanisms to spread health risk widely to support health plan premiums that are more affordable, and establishing opportunities to reward carriers and consumers whose behavior is consistent with quality, efficiency, and evidence-based best practices;

(h) Establishing a mechanism for payment of commissions when a small group is enrolled in the partnership by a health insurance broker or solicitor licensed under chapter 48.17 RCW or by an association or member-governed group;

(i) Establishing a mechanism to apply a surcharge to all health benefit plans, which shall be used only to pay for administrative and operational expenses of the partnership. The surcharge must be applied uniformly to all health benefit plans offered through the partnership and must be included in the premium for each health plan. As part of the premium, the surcharge shall be subject to the premium tax under RCW 48.14.020. Surcharges may not be used to pay any premium assistance payments under this chapter; and

(j) Entering into interdepartmental agreements with the health care authority, the office of the insurance commissioner, the department of social and health services, and any other state agencies necessary to implement this chapter; and

(3) An expectation that the successful bidder will begin offering health benefit plans under this act on January 1, 2009, following an open enrollment period that begins on October 1, 2008. With approval of the board established in section 204 of this act, the authority shall notify the apparently successful bidder no later than March 1, 2008.

NEW SECTION. **Sec. 204.** (1) The Washington health insurance partnership board is hereby established. The function of the board is to:

(a) Provide consultation regarding, and approve:

(i) The request for proposal issued under sections 202 and 203 of this act;

(ii) The choice of the successful bidder to the request for proposal issued under sections 202 and 203 of this act;

(iii) The health plan designs eligible for premium assistance payments under section 205 of this act;

(iv) Policies for operation of the partnership developed by the successful bidder;

(b) Conduct analyses and provide recommendations as requested by the legislature and the governor, with the assistance of the successful bidder, and staff from the health care authority and the office of the insurance commissioner.

(2) The board shall be composed of twelve members appointed by the governor as follows:

(a) A member in good standing of the American academy of actuaries;

(b) Two representatives of small businesses;

(c) Two employee health plan benefits specialists;

(d) Two representatives of health care consumers;

(e) A physician licensed in good standing under chapter 18.57 RCW;

(f) A health insurance broker licensed in good standing under chapter 48.17 RCW;

(g) The assistant secretary of the department of social and health services, health recovery services administration;

(h) The commissioner; and

(i) The administrator.

(3) The governor shall appoint the initial members of the board to staggered terms not to exceed four years. Initial appointments shall

be made on or before June 1, 2007. Members appointed thereafter shall serve two-year terms. Members of the board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060. The board shall prescribe rules for the conduct of its business. The board shall choose a chair and a vice-chair from among its members. Meetings of the board shall be at the call of the chair.

(4) The board may establish technical advisory committees or seek the advice of technical experts when necessary to execute the powers and duties included in this section.

(5) The board and employees of the board 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. Nothing in this section prohibits legal actions against the board to enforce the board's statutory or contractual duties or obligations.

NEW SECTION. **Sec. 205.** PREMIUM ASSISTANCE PROGRAM. (1) The successful bidder shall administer the partnership premium assistance program established in this section and remit premium assistance payments made on behalf of eligible partnership participants to carriers offering health plans through the partnership.

(2) In consultation with and upon approval by the partnership board, the authority shall designate health plans that qualify for premium assistance payments. At least four health plans shall be chosen, with multiple deductible and point-of-service cost-sharing options. The health plans shall range from catastrophic to comprehensive coverage. One health plan shall include services and cost-sharing comparable to those offered through the basic health plan under chapter 70.47 RCW, as of January 1, 2007. Designated health plans must include innovative components that will maximize the quality of care provided and result in improved health outcomes. These components include, but are not limited to:

(a) Preventive care;

(b) Wellness incentives, such as personal health assessments with health coaching, and smoking cessation benefits;

(c) Limited cost-sharing for preventive services, medications to manage chronic illness, and chronic care management visits;

(d) Payment for chronic care services, such as increased reimbursement for primary care visits, reimbursement for care coordination services, and coverage of group visits, telephone consultation, and nutrition education that enable patients to learn the skills needed to manage their chronic illness;

(e) Provider network development and payment policies related to quality of care, such as tiered networks, payment for performance in areas such as use of evidence-based protocols, delivery of preventive and chronic care management services, and quality and outcomes reporting.

(3) In consultation with and upon approval by the partnership board, the authority shall design a schedule of premium assistance payments that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The benchmark plan for purposes of designing the premium assistance payment schedule shall be the benefit design comparable to the basic health plan designated under subsection (2) of this section.

For employees of participating small employer plans, the premium assistance schedule shall be applied to the employee premium obligation remaining after employer premium contributions, so that employees benefit financially from their employer's contribution to the cost of their coverage through the partnership. Any surcharge included in the premium under section 203 of this act shall be included when determining the appropriate level of premium assistance payments.

(4) A financial sponsor may, with the prior approval of the administrator, pay the premium or any other amount on behalf of a partnership participant, by arrangement with the participant and through a mechanism acceptable to the administrator and the partnership.

(5) Beginning January 1, 2009, the successful bidder shall accept applications for premium assistance from partnership participants who have family income up to two hundred percent of the federal poverty level, as determined annually by the federal department of health and human services, on behalf of themselves, their spouses, and their dependent children.

(6) The successful bidder shall remit premium assistance payments in an amount determined under subsection (3) of this section to the carrier offering the health plan in which the partnership participant has chosen to enroll. If, however, the partnership participant has chosen to enroll in a high deductible health plan, any difference between the amount of premium assistance that the participant would receive and the applicable premium rate for the high deductible health plan shall be deposited into a health savings account for the benefit of that participant.

NEW SECTION. **Sec. 206.** Enrollment in the partnership premium assistance program is not an entitlement and shall not result in expenditures that exceed the amount that has been appropriated for the program in the operating budget. If it appears that continued enrollment will result in expenditures exceeding the appropriated level for a particular fiscal year, the successful bidder may freeze new enrollment in the program and establish a waiting list of eligible employees who shall receive subsidies only when sufficient funds are available.

NEW SECTION. **Sec. 207.** PARTNERSHIP PREMIUM ASSISTANCE ACCOUNT. The partnership premium assistance account is hereby established in the custody of the state treasurer. Any nongeneral fund--state funds obtained for the partnership premium assistance program and any funds appropriated for premium assistance under section 205 of this act shall be deposited in the partnership premium assistance account. Moneys in the account shall be used exclusively for the purposes of administering the partnership premium assistance program, including payments to carriers on behalf of partnership participants. Only the administrator or his or her designee may authorize expenditures from the account and make transfers from the account to the successful bidder for administration of the partnership premium assistance program. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 208.** FINANCIAL REPORT. The partnership shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report as of the end of its

fiscal year to the partnership board, to the governor, and to the legislature. The board may investigate the affairs of the partnership, may examine the properties and records of the partnership, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the partnership.

NEW SECTION. **Sec. 209.** REPORTS. No later than two years after the partnership begins operation and every year thereafter, the authority shall conduct a study of the partnership and the persons enrolled in the partnership and shall submit a written report to the governor and the legislature on the status and activities of the partnership based on data collected in the study. The report shall also be available to the general public. The study shall review:

(1) The operation and administration of the partnership, including surveys and reports of health benefit plans available to partnership participants and on the experience of the plans. The experience of the plans shall include data on enrollees in the partnership, the number of carriers offering coverage through the partnership, the health plans offered through the partnership, the operation and administration of the partnership premium assistance program, complaints data, partnership expenses, whether and how the partnership met its goals, and other information deemed pertinent by the authority; and

(2) Any significant observations regarding utilization and adoption of the partnership.

NEW SECTION. **Sec. 210.** REPORT ON PARTICIPATION OF ADDITIONAL MARKETS IN THE PARTNERSHIP AND INDIVIDUAL RESPONSIBILITY. On or before December 1, 2009, the partnership board shall submit a report and recommendations to the governor and the legislature regarding:

(1) The risks and benefits of additional markets participating in the partnership:

(a) The report shall examine the following markets:

(i) Association health plans;

(ii) Individual health insurance market;

(iii) Washington state health insurance pool under chapter 48.41 RCW;

(iv) Basic health plan, under chapter 70.47 RCW;

(v) Public employees' benefits board enrollees under chapter 41.05 RCW; and

(vi) Public school employees; and

(b) The report shall examine at least the following issues:

(i) The impact of these markets participating in the partnership, with respect to the utilization of services and cost of health plans offered through the partnership;

(ii) Whether any distinction should be made in participation between active and retired employees enrolled in public employees' benefits board plans, giving consideration to the implicit subsidy that nonmedicare-eligible retirees currently benefit from by being pooled with active employees, and how medicare-eligible retirees would be affected;

(iii) The impact of applying the insurance regulations in section 302 of this act, RCW 48.43.015, 48.43.025, and 48.43.035, on access to health services and the cost of coverage for these markets; and

(iv) If the board recommends the inclusion of additional markets, how the composition of the board should be modified to reflect the participation of these markets.

(2) The risks and benefits of establishing a requirement that residents of the state of Washington age eighteen and over obtain and maintain affordable creditable coverage, as defined in the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg(c)). The report shall address the question of how a requirement that residents maintain coverage could be enforced in the state of Washington.

NEW SECTION. **Sec. 211.** RULES. The administrator may adopt any rules necessary to implement this chapter.

PART III: INSURANCE REGULATION OF HEALTH BENEFIT PLANS OFFERED THROUGH THE PARTNERSHIP

Sec. 301. RCW 48.43.005 and 2006 c 25 s 16 are each amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Coverage supplemental to the coverage provided under chapter 55, Title 10, United States Code;

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

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

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

(21) "Participating small employer plan" means a group health plan, as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186), that is sponsored by a small employer and for which the plan sponsor has entered into an agreement with the partnership, in accordance with the provisions of section 203 of this act, for the partnership to offer and administer health insurance benefits for enrollees in the plan.

(22) "Partnership" means the Washington health insurance partnership established in sections 202 and 203 of this act.

(23) "Partnership participant" means a person who has been determined by the partnership to be, and continues to be, an employee of a participating small employer plan for purposes of obtaining coverage through the partnership or a former employee of a participating small employer plan who chooses to continue receiving coverage through the partnership following separation from employment.

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

((~~(22)~~)) (25) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(23)~~)) (26) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

((~~(24)~~)) (27) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed at least two but no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. A self-employed individual or sole proprietor must derive at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040,

schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

((~~(25)~~)) (28) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

((~~(26)~~)) (29) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 302.** HEALTH PLAN RATING METHODOLOGY. Premium rates for health benefit plans sold through the partnership are subject to the following provisions:

(1)(a) A carrier offering any health benefit plan through the partnership, or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection precludes a carrier from offering other health benefit plans that may have more comprehensive benefits than those included in the health benefit plan offered under this subsection. A carrier offering a health benefit plan under this subsection shall clearly disclose all covered benefits to the small employer in a brochure filed with the commissioner.

(b) A health benefit plan offered under this subsection shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of:

(i) For disability insurers, RCW 48.21.130, 48.21.140, 48.21.141, 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197, 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320;

(ii) For health care service contractors, RCW 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460; and

(iii) For health maintenance organizations, RCW 48.46.275, 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

(2) Nothing in this section prohibits a carrier from offering, or a purchaser from seeking, health benefit plans with benefits in excess of the health benefit plan offered under subsection (1) of this section. All forms, policies, and contracts shall be submitted for approval to the commissioner, and the rates of any plan offered under this section shall be reasonable in relation to the benefits.

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

(a) Geographic area;

(b) Family size;

(c) Age; and

(d) Wellness activities.

(4) Except as provided in subsection (11)(b) of this section, the adjustment for age in subsection (3)(c) of this section may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Participating individuals under the age of twenty shall be treated as those age twenty.

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

(6) The permitted rates for any age group shall be no more than

three hundred seventy-five percent of the lowest rate for all age groups.

(7) A discount for wellness activities is permitted to reflect actuarially justified differences in utilization or cost attributed to such programs.

(8) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect changes in government requirements affecting the health benefit plan.

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

(10) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. A carrier may develop its rates based on claims costs due to network provider reimbursement schedules or type of network. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(11)(a) Except to the extent provided otherwise in (b) of this subsection, adjusted community rates established under this section shall pool the medical experience of all of a carrier's enrollees purchasing coverage through the partnership. However, annual rate adjustments for each partnership plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire partnership pool, such overall adjustment to be approved by the commissioner, upon a showing by the carrier, certified by a member of the American academy of actuaries that: (i) The variation is a result of deductible leverage, benefit design, or provider network characteristics; and (ii) for a rate renewal period, the projected weighted average of all partnership health benefit plans will have a revenue neutral effect on the carrier's partnership pool. Variations of greater than four percentage points are subject to review by the commissioner, and must be approved or denied within sixty days of submittal. A variation that is not denied within sixty days shall be

deemed approved. The commissioner must provide to the carrier a detailed actuarial justification for any denial within thirty days of the denial.

(b) Carriers may treat persons under age thirty as a separate experience pool for purposes of establishing rates for health plans offered through the partnership. If the carrier chooses to create a separate experience pool for persons under age thirty, that experience pool is not subject to subsections (4) and (6) of this section. Individuals under age twenty must be rated as one age category. Adjustments for age for persons age twenty up to age thirty may not use age brackets smaller than five-year increments.

(12) Nothing in this section restricts the right of employees to collectively bargain for insurance providing benefits in excess of those provided in this section.

(13) A carrier must offer coverage to all partnership participants and their dependents. A carrier may not offer coverage to only certain partnership participants. A carrier may not modify a health plan with respect to a partnership participant or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the plan.

Sec. 303. RCW 48.43.015 and 2004 c 192 s 5 are each amended to read as follows:

(1) For a health benefit plan offered to a group <u>or through the partnership established in sections 202 and 203 of this act</u>, every health carrier shall reduce any preexisting condition exclusion, limitation, or waiting period in the group health plan in accordance with the provisions of section 2701 of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg).

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

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

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

(c) For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by chapter 192, Laws of 2004, and plans of the Washington state health insurance pool.

(3) For a health benefit plan offered ((~~to a small group~~)) through the partnership established in sections 202 and 203 of this act:

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

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

(c) For the purpose of this subsection, a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by chapter 192, Laws of 2004, and plans of the Washington state health insurance pool.

(4) For a health benefit plan offered to an individual, other than an individual to whom subsection (5) of this section applies, every health carrier shall credit any preexisting condition waiting period in that plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new health plan in a group health benefit plan or an individual health

benefit plan, other than a catastrophic health plan, and (a) the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the health benefit plan the individual seeks to purchase; or (b) the person is seeking an individual health benefit plan due to his or her change of residence from one geographic area in Washington state to another geographic area in Washington state where his or her current health plan is not offered, if application for coverage is made within ninety days of relocation; or (c) the person is seeking an individual health benefit plan: (i) Because a health care provider with whom he or she has an established care relationship and from whom he or she has received treatment within the past twelve months is no longer part of the carrier's provider network under his or her existing Washington individual health benefit plan; and (ii) his or her health care provider is part of another carrier's provider network; and (iii) application for a health benefit plan under that carrier's provider network individual coverage is made within ninety days of his or her provider leaving the previous carrier's provider network. The carrier must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection (4), a preceding health plan includes an employer-provided self-funded health plan, the basic health plan's offering to health coverage tax credit eligible enrollees as established by chapter 192, Laws of 2004, and plans of the Washington state health insurance pool.

(5) Every health carrier shall waive any preexisting condition waiting period in its individual plans 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. Sec. 300gg-41(b)).

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

Sec. 304. RCW 48.43.025 and 2001 c 196 s 9 are each amended to read as follows:

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

(2) For group health benefit plans ((~~for small groups~~)) offered through the partnership established in sections 202 and 203 of this act, no carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and no carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions. Except that a carrier may impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment within six months before the effective date of coverage. Any preexisting condition waiting period or limitation relating to pregnancy as a preexisting condition shall be imposed only to the extent allowed in the federal health insurance portability and accountability act of 1996.

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

Sec. 305. RCW 48.43.035 and 2004 c 244 s 4 are each amended to read as follows:

For group health benefit plans and for health benefit plans offered through the partnership established in sections 202 and 203 of this act, the following shall apply:

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

(2) Except as provided in subsection (5) of this section, all health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. For the purposes of this section, a plan is "renewed" when it is continued beyond the earliest date upon which, at the carrier's sole option, the plan could have been terminated for other than nonpayment of premium. The carrier may consider the group's anniversary date as the renewal date for purposes of complying with the provisions of this section.

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

(a) Nonpayment of premium;

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

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

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

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

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

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

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

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

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

(c) No sooner than January 1, 2005, a carrier discontinues offering a particular type of health benefit plan offered for groups of up to two hundred if: (i) The carrier provides notice to each group of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the carrier offers to each group provided coverage of this type the option to enroll, with regard to small employer groups, in any other small employer group plan, or with regard to groups of up to two hundred, in any other applicable group plan, currently being offered by the carrier in the applicable group market; and (iii) in exercising the option to discontinue coverage of this type and in offering the option of coverage under (c)(ii) of this subsection, the carrier acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage;

(d) A carrier discontinues offering all health coverage in the small group market or for groups of up to two hundred, or both markets, in the state and discontinues coverage under all existing group health benefit plans in the applicable market involved if: (i) The carrier provides notice to the commissioner of its intent to discontinue offering all such coverage in the state and its intent to discontinue coverage under all such existing health benefit plans at least one hundred eighty days prior to the date of the discontinuation of coverage under all such existing health benefit plans; and (ii) the carrier provides notice to each covered group of the intent to discontinue the existing health benefit plan at least one hundred eighty days prior to the date of discontinuation. In the case of discontinuation under this subsection, the carrier may not issue any

group health coverage in this state in the applicable group market involved for a five-year period beginning on the date of the discontinuation of the last health benefit plan not so renewed. This subsection (4) does not require a carrier to provide notice to the commissioner of its intent to discontinue offering a health benefit plan to new applicants when the carrier does not discontinue coverage of existing enrollees under that health benefit plan; or

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

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

(6) Notwithstanding any other provision of this section, the guarantee of continuity of coverage applies to a group of one only if: (a) The carrier continues to offer any other small employer group plan in which the group of one was eligible to enroll on the day prior to June 10, 2004; and (b) the person continues to qualify as a group of one under the criteria in place on the day prior to June 10, 2004.

NEW SECTION. **Sec. 306.** INSURANCE MARKET CONSOLIDATION IN THE PARTNERSHIP. A carrier shall not issue or renew a small group health benefit plan to a small employer other than through the partnership established in sections 202 and 203 of this act after January 1, 2009.

Sec. 307. RCW 48.21.047 and 2005 c 223 s 11 are each amended to read as follows:

(1) An insurer may not offer any health benefit plan ((~~to any small employer without complying with RCW 48.21.045(3)~~)) through the partnership established in sections 202 and 203 of this act without complying with section 302 of this act.

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to ((~~RCW 48.21.045(3)~~)) section 302(3) of this act.

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 308. RCW 48.44.024 and 2003 c 248 s 15 are each amended to read as follows:

(1) A health care service contractor may not offer any health benefit plan ((~~to any small employer without complying with RCW 48.44.023(3)~~)) through the partnership established in sections 202 and 203 of this act without complying with section 302 of this act.

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and the plans are not subject to ((~~RCW 48.44.023(3)~~)) section 302(3) of this act.

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 309. RCW 48.46.068 and 2003 c 248 s 16 are each amended to read as follows:

(1) A health maintenance organization may not offer any health benefit plan ((~~to any small employer without complying with RCW 48.46.066(3)~~)) through the partnership established in sections 202 and 203 of this act without complying with section 302 of this act.

(2) Employers purchasing health plans provided through associations or through member-governed groups formed specifically for the purpose of purchasing health care are not small employers and are not subject to ((~~RCW 48.46.066(3)~~)) section 302(3) of this act.

(3) For purposes of this section, "health benefit plan," "health plan," and "small employer" mean the same as defined in RCW 48.43.005.

Sec. 310. RCW 48.43.028 and 2001 c 196 s 10 are each amended to read as follows:

To the extent required of the federal health insurance portability and accountability act of 1996, the eligibility of an employer or group to purchase a health benefit plan set forth in ((~~RCW 48.21.045(1)(b), 48.44.023(1)(b), and 48.46.066(1)(b)~~)) section 302(1) of this act must be extended to all small employers and small groups as defined in RCW 48.43.005.

NEW SECTION. **Sec. 311.** RULES. The commissioner may adopt any rules necessary to implement this chapter.

PART IV: EMPLOYER RESPONSIBILITY

NEW SECTION. **Sec. 401.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Employee" means any individual employed by any employer.

(2) "Employer" means an employer as defined in RCW 49.46.010.

(3) "Partnership" means the entity established in sections 202 and 203 of this act.

NEW SECTION. **Sec. 402.** Beginning January 1, 2009, each employer that has entered into an agreement with the partnership, in accordance with this act, for the partnership to offer and administer health insurance benefits for its employees shall:

(1) Adopt and maintain a cafeteria plan that satisfies 26 U.S.C. Sec. 125 that provides a premium only plan option so that employees can use salary deductions to pay health plan premiums. A copy of such cafeteria plan shall be filed with the partnership; and

(2) Collect and transmit amounts designated as payroll deductions by employees to the partnership for those employees purchasing coverage through the partnership.

NEW SECTION. **Sec. 403.** The attorney general shall enforce sections 401 and 402 of this act and has the authority to seek and obtain injunctive relief in a court of appropriate jurisdiction.

PART V: INDEPENDENT STUDY OF HEALTH BENEFIT REQUIREMENTS

NEW SECTION. **Sec. 501.** (1) The office of the insurance commissioner shall contract for an independent study of health benefit mandates, rating requirements, and insurance statutes and rules to determine the impact on premiums and individuals' health if those statutes or rules were amended or repealed.

(2) The office of the insurance commissioner shall submit an interim report to the governor and appropriate committees of the

legislature by December 1, 2007, and a final report by December 1, 2008.

PART VI: CONFORMING AMENDMENTS, REPEALERS, AND EFFECTIVE DATES

NEW SECTION. **Sec. 601.** (1) Sections 102 and 201 through 211 of this act constitute a new chapter in Title 41 RCW.

(2) Sections 302, 306, and 307 of this act are each added to chapter 48.43 RCW.

(3) Sections 401 through 403 of this act constitute a new chapter in Title 49 RCW.

NEW SECTION. **Sec. 602.** Part headings and captions used in this act are not any part of the law.

NEW SECTION. **Sec. 603.** The following acts or parts of acts are each repealed, effective January 1, 2009:

(1) RCW 48.21.045 (Health plan benefits for small employers--Coverage--Exemption from statutory requirements--Premium rates--Requirements for providing coverage for small employers--Definitions) and 2004 c 244 s 1, 1995 c 265 s 14, & 1990 c 187 s 2;

(2) RCW 48.44.023 (Health plan benefits for small employers--Coverage--Exemption from statutory requirements--Premium rates--Requirements for providing coverage for small employers) and 2004 c 244 s 7, 1995 c 265 s 16, & 1990 c 187 s 3;

(3) RCW 48.46.066 (Health plan benefits for small employers--Coverage--Exemption from statutory requirements--Premium rates--Requirements for providing coverage for small employers) and 2004 c 244 s 9, 1995 c 265 s 18, & 1990 c 187 s 4;

(4) RCW 70.47A.010 (Finding--Intent) and 2006 c 255 s 1;

(5) RCW 70.47A.020 (Definitions) and 2006 c 255 s 2;

(6) RCW 70.47A.030 (Program established--Administrator duties) and 2006 c 255 s 3;

(7) RCW 70.47A.040 (Premium subsidies--Enrollment verification, status changes--Administrator duties--Rules) and 2006 c 255 s 4;

(8) RCW 70.47A.050 (Enrollment to remain within appropriation) and 2006 c 255 s 5;

(9) RCW 70.47A.060 (Rules) and 2006 c 255 s 6;

(10) RCW 70.47A.070 (Reports) and 2006 c 255 s 7;

(11) RCW 70.47A.080 (Small employer health insurance partnership program account) and 2006 c 255 s 8;

(12) RCW 70.47A.090 (State children's health insurance program--Federal waiver request) and 2006 c 255 s 9; and

(13) RCW 70.47A.900 (Captions not law--2006 c 255) and 2006 c 255 s 11.

NEW SECTION. **Sec. 604.** Sections 302 through 310 of this act take effect January 1, 2009.

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