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HOUSE BILL 1569

State of Washington 60th Legislature 2007 Regular Session

By Representatives Cody, Campbell, Morrell, Linville, Moeller, Green, Seaquist, Conway, Dickerson, Appleton, McIntire, McCoy, Kagi, Pedersen, Kenney, Lantz, Santos, Wood and Ormsby

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1 AN ACT Relating to reforming the health care system in Washington
2 state; amending RCW 41.05.021, 48.43.005, 48.43.015, 48.43.025, and
3 48.43.035; adding new sections to chapter 48.43 RCW; adding a new
4 chapter to Title 41 RCW; adding a new chapter to Title 49 RCW; creating
5 new sections; repealing RCW 48.01.260, 48.20.025, 48.20.028, 48.20.029,
6 48.21.045, 48.21.047, 48.43.012, 48.43.018, 48.43.038, 48.43.041,
7 48.44.017, 48.44.021, 48.44.022, 48.44.023, 48.44.024, 48.46.062,
8 48.46.063, 48.46.064, 48.46.066, 48.46.068, 70.47A.010, 70.47A.020,
9 70.47A.030, 70.47A.040, 70.47A.050, 70.47A.060, 70.47A.070, 70.47A.080,
10 70.47A.090, 70.47A.900, 48.41.010, 48.41.020, 48.41.030, 48.41.037,
11 48.41.040, 48.41.050, 48.41.060, 48.41.070, 48.41.080, 48.41.090,
12 48.41.100, 48.41.110, 48.41.120, 48.41.130, 48.41.140, 48.41.150,
13 48.41.160, 48.41.170, 48.41.190, 48.41.200, 48.41.210, 48.41.900, and
14 48.41.910; and providing effective dates.

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

16 **PART I: FINDINGS AND INTENT**

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

1 (1) The people of Washington have expressed strong concerns about
2 health care costs and access to needed health services. Even if
3 currently insured, they are not confident that they will continue to
4 have health insurance coverage in the future and feel that they are
5 getting less, but spending more.
6 (2) Many employers, especially small employers, struggle with the
7 cost of providing employer-sponsored health insurance coverage to their
8 employees, while others are unable to offer employer-sponsored health
9 insurance due to its high cost.
10 (3) Six hundred thousand Washingtonians are uninsured.
11 Three-quarters work or have a working family member; two-thirds are low
12 income; and one-half are young adults. Many are low-wage workers who
13 are not offered, or eligible for, employer-sponsored coverage. Others
14 struggle with the burden of paying their share of the costs of
15 employer-sponsored health insurance, while still others turn down their
16 employer's offer of coverage due to its costs.
17 (4) Access to health insurance and other health care spending has
18 resulted in improved health for many Washingtonians. Yet, we are not
19 receiving as much value as we should for each health care dollar spent
20 in Washington state. By failing to sufficiently focus our efforts on
21 prevention and management of chronic diseases, such as diabetes,
22 asthma, and heart disease, too many Washingtonians suffer from
23 complications of their illnesses. By failing to make health insurance
24 coverage affordable for low-wage workers and self-employed people,
25 health problems that could be treated in a doctor's office are treated
26 in the emergency room or hospital. By failing to focus on the most
27 effective ways to maintain our health and treat disease, Washingtonians
28 have not made lifestyle changes proven to improve health, nor do they
29 receive the most effective care.

30 NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT. The legislature
31 intends, through the public/private partnership reflected in this act,
32 to improve our current health care system so that:
33 (1) Health insurance coverage is more affordable for employers,
34 employees, self-employed people, and other individuals;
35 (2) The process of choosing and purchasing health insurance
36 coverage is well-informed, clearer, and simpler;

(3) Prevention, chronic care management, wellness, and improved quality of care are a fundamental part of our health care 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: HEALTH INSURANCE CONNECTOR

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) "Connector" means the Washington state health insurance connector established in section 203 of this act.

(7) "Connector board" and "board" means the board of the Washington state health insurance connector established in section 204 of this act.

(8) "Eligible individual" means an individual, including a sole proprietor, who is a resident of Washington state and is not offered subsidized health insurance by an employer with more than fifty employees. "Eligible individual" includes any individual who is eligible for benefits under section 210 of the federal trade act of 2002, at 26 U.S.C. Sec. 35(c).

(9) "Eligible small group" or "eligible small employer" means a small group or small employer as defined in RCW 48.43.005.

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

(11) "Participating individual" means a person who has been determined by the connector to be, and continues to be, an eligible individual or an employee of a participating small employer plan for purposes of obtaining coverage through the connector.

1 (12) "Participating small employer plan" means a group health plan,
2 as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186),
3 that is sponsored by a small employer and for which the plan sponsor
4 has entered into an agreement with the connector, in accordance with
5 the provisions of section 208 of this act, for the connector to offer
6 and administer health insurance benefits for enrollees in the plan.
7 (13) "Preexisting condition" means a preexisting condition as
8 defined in RCW 48.43.005.
9 (14) "Premium assistance payment" means a payment made to carriers
10 by the connector as provided in section 209 of this act.

11 **Sec. 202.** RCW 41.05.021 and 2006 c 103 s 2 are each amended to
12 read as follows:
13 (1) The Washington state health care authority is created within
14 the executive branch. The authority shall have an administrator
15 appointed by the governor, with the consent of the senate. The
16 administrator shall serve at the pleasure of the governor. The
17 administrator may employ up to seven staff members, who shall be exempt
18 from chapter 41.06 RCW, and any additional staff members as are
19 necessary to administer this chapter. The administrator may delegate
20 any power or duty vested in him or her by this chapter, including
21 authority to make final decisions and enter final orders in hearings
22 conducted under chapter 34.05 RCW. The primary duties of the authority
23 shall be to: Administer state employees' insurance benefits and
24 retired or disabled school employees' insurance benefits; administer
25 the basic health plan pursuant to chapter 70.47 RCW; study state-
26 purchased health care programs in order to maximize cost containment in
27 these programs while ensuring access to quality health care; and
28 implement state initiatives, joint purchasing strategies, and
29 techniques for efficient administration that have potential application
30 to all state-purchased health services. The authority's duties
31 include, but are not limited to, the following:
32 (a) To administer health care benefit programs for employees and
33 retired or disabled school employees as specifically authorized in RCW
34 41.05.065 and in accordance with the methods described in RCW
35 41.05.075, 41.05.140, and other provisions of this chapter;
36 (b) To analyze state-purchased health care programs and to explore

1 options for cost containment and delivery alternatives for those
2 programs that are consistent with the purposes of those programs,
3 including, but not limited to:

4 (i) Creation of economic incentives for the persons for whom the
5 state purchases health care to appropriately utilize and purchase
6 health care services, including the development of flexible benefit
7 plans to offset increases in individual financial responsibility;

8 (ii) Utilization of provider arrangements that encourage cost
9 containment, including but not limited to prepaid delivery systems,
10 utilization review, and prospective payment methods, and that ensure
11 access to quality care, including assuring reasonable access to local
12 providers, especially for employees residing in rural areas;

13 (iii) Coordination of state agency efforts to purchase drugs
14 effectively as provided in RCW 70.14.050;

15 (iv) Development of recommendations and methods for purchasing
16 medical equipment and supporting services on a volume discount basis;

17 (v) Development of data systems to obtain utilization data from
18 state-purchased health care programs in order to identify cost centers,
19 utilization patterns, provider and hospital practice patterns, and
20 procedure costs, utilizing the information obtained pursuant to RCW
21 41.05.031; and

22 (vi) In collaboration with other state agencies that administer
23 state purchased health care programs, private health care purchasers,
24 health care facilities, providers, and carriers:

25 (A) Use evidence-based medicine principles to develop common
26 performance measures and implement financial incentives in contracts
27 with insuring entities, health care facilities, and providers that:

28 (I) Reward improvements in health outcomes for individuals with
29 chronic diseases, increased utilization of appropriate preventive
30 health services, and reductions in medical errors; and

31 (II) Increase, through appropriate incentives to insuring entities,
32 health care facilities, and providers, the adoption and use of
33 information technology that contributes to improved health outcomes,
34 better coordination of care, and decreased medical errors;

35 (B) Through state health purchasing, reimbursement, or pilot
36 strategies, promote and increase the adoption of health information
37 technology systems, including electronic medical records, by hospitals

1 as defined in RCW 70.41.020(4), integrated delivery systems, and
2 providers that:

3 (I) Facilitate diagnosis or treatment;

4 (II) Reduce unnecessary duplication of medical tests;

5 (III) Promote efficient electronic physician order entry;

6 (IV) Increase access to health information for consumers and their
7 providers; and

8 (V) Improve health outcomes;

9 (C) Coordinate a strategy for the adoption of health information
10 technology systems using the final health information technology report
11 and recommendations developed under chapter 261, Laws of 2005((.));

12 (c) To analyze areas of public and private health care interaction;

13 (d) To provide information and technical and administrative
14 assistance to the board;

15 (e) To review and approve or deny applications from counties,
16 municipalities, and other political subdivisions of the state to
17 provide state-sponsored insurance or self-insurance programs to their
18 employees in accordance with the provisions of RCW 41.04.205, setting
19 the premium contribution for approved groups as outlined in RCW
20 41.05.050;

21 (f) To establish billing procedures and collect funds from school
22 districts in a way that minimizes the administrative burden on
23 districts;

24 (g) To publish and distribute to nonparticipating school districts
25 and educational service districts by October 1st of each year a
26 description of health care benefit plans available through the
27 authority and the estimated cost if school districts and educational
28 service district employees were enrolled;

29 (h) To administer the Washington state health insurance connector
30 established in sections 203 through 205 of this act;

31 (i) To apply for, receive, and accept grants, gifts, and other
32 payments, including property and service, from any governmental or
33 other public or private entity or person, and make arrangements as to
34 the use of these receipts to implement initiatives and strategies
35 developed under this section; and

36 (((i))) (j) To promulgate and adopt rules consistent with this
37 chapter as described in RCW 41.05.160.

1 (2) On and after January 1, 1996, the public employees' benefits
2 board may implement strategies to promote managed competition among
3 employee health benefit plans. Strategies may include but are not
4 limited to:
5 (a) Standardizing the benefit package;
6 (b) Soliciting competitive bids for the benefit package;
7 (c) Limiting the state's contribution to a percent of the lowest
8 priced qualified plan within a geographical area;
9 (d) Monitoring the impact of the approach under this subsection
10 with regards to: Efficiencies in health service delivery, cost shifts
11 to subscribers, access to and choice of managed care plans statewide,
12 and quality of health services. The health care authority shall also
13 advise on the value of administering a benchmark employer-managed plan
14 to promote competition among managed care plans.

15 NEW SECTION. **Sec. 203.** (1) The Washington state health insurance
16 connector is hereby established. The connector shall be administered
17 by the administrator and governed by the Washington state health
18 insurance connector board established in section 204 of this act. The
19 purpose of the connector is to facilitate the availability, choice, and
20 adoption of private health insurance plans to eligible individuals and
21 small groups, as provided in this chapter.
22 (2) With the approval of the board, the administrator, or his or
23 her designee, has the following powers and duties:
24 (a) Plan, direct, coordinate, and execute administrative functions
25 in conformity with the policies and directives of the board;
26 (b) Employ professional and clerical staff as necessary;
27 (c) Report to the board on all operations under his or her control
28 and supervision;
29 (d) Prepare an annual budget and manage the administrative expenses
30 of the connector; and
31 (e) Undertake any other activities necessary to implement the
32 powers and duties set forth in this chapter.

33 NEW SECTION. **Sec. 204.** (1) The Washington state health insurance
34 connector board is hereby established. The function of the board is to
35 develop and approve policies necessary for operation of the Washington
36 state health insurance connector.

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

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

(b) A health economist;

(c) Two representatives of small businesses;

(d) Two employee health plan benefits specialists;

(e) Two representatives of health care consumers;

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

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

(h) A representative of organized labor;

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

(j) The commissioner; and

(k) The administrator.

No member may be an employee of any licensed carrier authorized to do business in the state of Washington.

(3) The governor shall appoint the initial members of the board to staggered terms not to exceed four years. 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 administrator shall serve as chair of the board. 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 section 205 of this act.

NEW SECTION. **Sec. 205.** The connector board has the following duties and powers:

(1) Develop and approve a benefit design for health benefit plans that will be sold by carriers as individual health plans through the connector. The connector shall offer at least four, but no more than five, benefit packages. For each benefit package, the board shall develop at least three deductible and point-of-service cost-sharing options.

(a) The benefit packages shall include:

1 (i) A high deductible health plan that meets the federal
2 requirements necessary to be offered in conjunction with a health
3 savings account. The high deductible health plan must offer all
4 preventive services allowable under section 223 of the federal internal
5 revenue code;
6 (ii) A benefit package that includes services comparable to those
7 offered through the basic health plan under chapter 70.47 RCW, as of
8 January 1, 2007. One of the deductible and cost-sharing options
9 offered with this benefit package shall be the deductible and
10 cost-sharing provisions of the basic health plan as of January 1, 2007;
11 (iii) A benefit package that provides first dollar coverage for a
12 fixed number of provider visits, and a fixed dollar amount of
13 laboratory or diagnostic services prior to an enrollee being required
14 to satisfy their deductible;
15 (iv) A benefit package that includes services comparable to those
16 offered through the public employees' benefits board under chapter
17 41.05 RCW;
18 (b) In designing the benefit packages, the board shall make every
19 effort to include innovative components that will maximize the quality
20 of care provided and result in improved health outcomes. These
21 components include, but are not limited to:
22 (i) Preventive care;
23 (ii) Wellness incentives, such as personal health assessments with
24 health coaching, and smoking cessation benefits;
25 (iii) Limited cost-sharing for preventive services, medications to
26 manage chronic illness, and chronic care management visits;
27 (iv) Payment for chronic care services, such as increased
28 reimbursement for primary care visits, reimbursement for care
29 coordination services, and coverage of group visits, telephone
30 consultation, and nutrition education that enable patients to learn the
31 skills needed to manage their chronic illness;
32 (v) Provider network development and payment policies related to
33 quality of care, such as tiered networks, payment for performance in
34 areas such as use of evidence-based protocols, delivery of preventive
35 and chronic care management services, and quality and outcomes
36 reporting;
37 (2) Establish procedures for the enrollment of eligible individuals
38 and small groups, including:

1 (a) Publicizing the existence of the connector and disseminating
2 information on eligibility requirements and enrollment procedures for
3 the connector;
4 (b) Establishing procedures to determine each applicant's
5 eligibility for purchasing insurance offered by the connector,
6 including a standard application form for eligible individuals and
7 small groups seeking to purchase health insurance through the
8 connector, as well as persons seeking a premium assistance payment.
9 The application shall include information necessary to determine an
10 applicant's eligibility, previous health insurance coverage history,
11 and payment method;
12 (c) Establishing rules related to minimum participation of
13 employees in small groups seeking to purchase health insurance through
14 the connector;
15 (d) Preparing and distributing certificate of eligibility forms and
16 application forms to insurance brokers and the general public; and
17 (e) Establishing and administering procedures for the election of
18 coverage by participating individuals during open enrollment periods
19 and outside of open enrollment periods upon the occurrence of any
20 qualifying event specified in the federal health insurance portability
21 and accountability act of 1996 or applicable state law. The procedures
22 shall include preparing and distributing to participating individuals:
23 (i) Descriptions of the coverage, benefits, limitations,
24 copayments, and premiums for all participating plans; and
25 (ii) Forms and instructions for electing coverage and arranging
26 payment for coverage;
27 (3) Establish and manage a system of collecting and transmitting to
28 the applicable carriers all premium payments or contributions made by
29 or on behalf of participating individuals, including developing
30 mechanisms to receive and process automatic payroll deductions for
31 participating individuals enrolled in small employer plans;
32 (4) Establish, if the board finds it necessary, a risk adjustment
33 mechanism for premiums paid to carriers;
34 (5) Establish and manage a system for determining eligibility for
35 premium assistance payments and remitting premium assistance payments
36 to the carriers, as provided in section 209 of this act;
37 (6) Establish a plan for operating a health insurance service
38 center to provide eligible individuals and small groups with

1 information on the connector and manage connector enrollment, and for
2 publicizing the existence of the connector and the connector's
3 eligibility requirements and enrollment procedures;
4 (7) Establish procedures for coordinating with the office of the
5 insurance commissioner regarding administration of the reinsurance
6 program established in section 501 of this act;
7 (8) Establish, beginning January 1, 2012, and annually thereafter,
8 a schedule to determine whether creditable coverage is affordable for
9 residents of Washington state at varying income levels. The schedule
10 shall be developed for purposes of implementing section 404 of this
11 act. In developing the schedule, the board shall examine the
12 percentage of household income that it is reasonable to ask Washington
13 state residents to dedicate to the purchase of creditable coverage,
14 based upon a family's income relative to varying percentages of the
15 federal poverty level, as determined annually by the federal department
16 of health and human services;
17 (9) Establish other procedures for operations of the connector,
18 including but not limited to procedures to:
19 (a) Seek and receive any grant funding from the federal government,
20 departments or agencies of the state, and private foundations;
21 (b) Contract with professional service firms as may be necessary in
22 the board's judgment, and to fix their compensation;
23 (c) Contract with companies which provide third-party
24 administrative and billing services for insurance products;
25 (d) Charge and equitably apportion among participating institutions
26 its administrative costs and expenses incurred in the exercise of the
27 powers and duties granted by this chapter;
28 (e) Adopt bylaws for the regulation of its affairs and the conduct
29 of its business;
30 (f) Sue and be sued in its own name, plead, and be impleaded;
31 (g) Establish lines of credit, and establish one or more cash and
32 investment accounts to receive payments for services rendered and
33 appropriations from the state, and for all other business activity
34 granted by this chapter except to the extent otherwise limited by any
35 applicable provision of the employee retirement income security act of
36 1974; and
37 (h) Enter into interdepartmental agreements with the office of the

insurance commissioner, department of social and health services, and any other state agencies the board deems necessary to implement this chapter; and

(10) Begin offering health benefit plans under this act on September 1, 2008.

NEW SECTION. **Sec. 206.** ENROLLMENT AND COVERAGE ELECTION. Any eligible individual may apply to participate in the connector. An employer, a labor union, or an educational, professional, civic, trade, church, or social organization that has eligible individuals as employees or members may apply on behalf of those eligible persons. Upon determination by the connector that an individual is eligible to participate in the connector, he or she may enroll in a health plan offered through the connector during the next open enrollment period or, 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. The initial open enrollment period is September 1, 2008, through November 30, 2008.

NEW SECTION. **Sec. 207.** HEALTH BENEFIT PLANS OFFERED THROUGH THE CONNECTOR. (1) The connector shall not sponsor any health benefit plan, or contract with any carrier to offer any health benefit plan, that has not first been certified by the commissioner in accordance with section 301 of this act.

(2)(a) Except as provided in (b) of this subsection, no carrier may offer a health plan through the connector unless the carrier has agreed to offer all of the health plan options approved by the connector board under section 205(1) of this act.

(b) A carrier that has contracted exclusively with the department of social and health services to serve medicaid program clients, or with the authority to serve basic health plan enrollees, may offer only the health plan approved by the connector board under section 205(1)(a)(ii) of this act and may offer coverage only to persons receiving premium assistance under section 209 of this act.

NEW SECTION. **Sec. 208.** PARTICIPATING SMALL EMPLOYER PLANS. (1) Any small employer may apply to the connector to be the sponsor of a participating small employer plan.

1 (2) Any small employer seeking to be the sponsor of a participating
2 small employer plan shall, as a condition of participation in the
3 connector, enter into a binding agreement with the connector that
4 includes the following conditions:
5 (a) The sponsoring small employer designates the connector to be
6 the plan's administrator for the employer's group health plan, and the
7 connector agrees to undertake the obligations required of a plan
8 administrator under federal law;
9 (b) Any individual eligible to participate in the connector by
10 reason of his or her eligibility for coverage under the employer's
11 participating small employer plan, regardless of whether any such
12 individual would otherwise qualify as an eligible individual if not
13 enrolled in the participating small employer plan, may elect coverage
14 under any health plan offered through the connector, and neither the
15 employer nor the connector shall limit such individual's choice of
16 coverage from among all the health plans offered;
17 (c) The small employer agrees that, for the term of the agreement,
18 the small employer will not offer to individuals eligible to
19 participate in the connector by reason of their eligibility for
20 coverage under the employer's participating small employer plan any
21 separate or competing health plan, regardless of whether any such
22 individuals would otherwise qualify as eligible individuals if not
23 enrolled in the participating small employer plan;
24 (d) The small employer reserves the right to determine the criteria
25 for eligibility and enrollment in the participating small employer plan
26 and the terms and amounts of the small employer's contributions to that
27 plan, so long as for the term of the agreement with the connector the
28 small employer agrees not to alter or amend any criteria or
29 contribution amounts at any time other than during an annual period
30 designated by the connector for participating small employer plans to
31 make such changes in conjunction with the connector's annual open
32 enrollment period;
33 (e) The small employer agrees to make available to the connector
34 any of the employer's documents, records, or information, including
35 copies of the employer's federal and state tax and wage reports, that
36 the administrator reasonably determines are necessary for the connector
37 to verify:

(i) That the small employer is in compliance with the terms of its agreement with the connector governing the employer's sponsorship of a participating small employer plan;

(ii) That the participating small employer plan is in compliance with applicable laws relating to employee welfare benefit plans, particularly those relating to nondiscrimination in coverage; and

(iii) The eligibility, under the terms of the small employer's plan, of those individuals enrolled in the participating small employer plan;

(f) The small employer agrees to also sponsor a "cafeteria plan" as permitted under federal law, 26 U.S.C. Sec. 125, for all employees eligible for coverage under the employer's participating employer plan.

NEW SECTION. **Sec. 209.** CONNECTOR PREMIUM ASSISTANCE PROGRAM. (1) The connector shall administer the connector premium assistance program established in this section and remit premium assistance payments to carriers offering health plans through the connector.

(2) Beginning January 1, 2009, the administrator shall accept applications for premium assistance from eligible individuals and employees of participating small employer plans 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.

(3) The connector board shall design and implement 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 established under section 205(1)(a)(ii) of this act with the deductible and cost-sharing of the basic health plan benefit package in effect on January 1, 2007.

The premium assistance schedule shall be applied to eligible individuals, and to the employee premium obligation remaining after employer premium contributions for employees of participating small employer plans, so that employees benefit financially from their employer's contribution to the cost of their coverage through the connector. Any surcharge included in the premium under section 212 of

1 this act shall be included when determining the appropriate level of
2 premium assistance payments.
3 (4) A financial sponsor may, with the prior approval of the
4 administrator, pay the premium or any other amount on behalf of an
5 eligible individual or employee of a participating small employer plan,
6 by arrangement with the individual or employee and through a mechanism
7 acceptable to the administrator. The administrator shall establish a
8 mechanism for receiving premium payments from the United States
9 internal revenue service for eligible individuals who are eligible for
10 benefits under section 210 of the federal trade act of 2002, at 26
11 U.S.C. Sec. 35(c).
12 (5) The connector shall remit the premium assistance in an amount
13 determined under subsection (3) of this section to the carrier offering
14 the health plan in which the eligible individual or employee of a
15 participating small employer plan has chosen to enroll. If, however,
16 such individual or employee has chosen to enroll in a high deductible
17 health plan, any difference between the amount of premium assistance
18 that the individual or employee would receive and the applicable
19 premium rate for the high deductible health plan shall be deposited
20 into a health savings account for the benefit of that individual or
21 employee.
22 (6) As of January 1, 2009, all basic health plan enrollees under
23 chapter 70.47 RCW shall transition to the premium assistance program.
24 The authority shall provide information and assistance necessary to
25 allow enrollees to successfully transition to the premium assistance
26 program, including assistance with enrolling in the connector and
27 choosing a health plan during the 2008 open enrollment period.

28 NEW SECTION. **Sec. 210.** CONNECTOR PREMIUM ASSISTANCE ACCOUNT. The
29 connector premium assistance account is hereby established in the
30 custody of the state treasurer. Any nongeneral fund--state funds
31 collected for the connector premium assistance program shall be
32 deposited in the connector premium assistance account. Moneys in the
33 account shall be used exclusively for the purposes of administering the
34 connector premium assistance account, including payments to carriers on
35 behalf of eligible individuals and employees of participating small
36 employer plans. Only the administrator or his or her designee may

authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

NEW SECTION. **Sec. 211.** BROKER COMMISSIONS. When an eligible individual or eligible small group is enrolled in the connector by a health insurance broker or solicitor licensed under chapter 48.17 RCW, the connector shall pay the broker a commission determined by the connector board. In setting the commission, the connector board shall consider rates of commissions paid to brokers for health plans issued under chapters 48.21, 48.44, and 48.46 RCW as of January 1, 2007.

NEW SECTION. **Sec. 212.** SURCHARGE FOR CONNECTOR EXPENSES. (1) The connector is authorized to apply a surcharge to all health benefit plans, which shall be used only to pay for administrative and operational expenses of the connector. Such a surcharge shall be applied uniformly to all health benefit plans offered through the connector and shall 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. These surcharges shall not be used to pay any premium assistance payments under this chapter.

(2) Each carrier participating in the connector shall be required to furnish such reasonable reports as the board determines necessary to enable the executive director to carry out his or her duties under this chapter.

NEW SECTION. **Sec. 213.** FINANCIAL REPORT. The connector 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 its board, to the governor, and to the legislature, such reports to be in a form prescribed by the board. The board may investigate the affairs of the connector, may severally examine the properties and records of the connector, and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the connector. The connector shall be subject to biennial audit by the state auditor.

1 <u>NEW SECTION.</u> **Sec. 214.** REPORTS. No later than two years after
2 the connector begins operation and every year thereafter, the connector
3 shall conduct a study of the connector and the persons enrolled in the
4 connector and shall submit a written report to the governor and the
5 legislature on the status and activities of the connector based on data
6 collected in the study. The report shall also be available to the
7 general public. The study shall review:
8 (1) The operation and administration of the connector, including
9 surveys and reports of health benefit plans available to participating
10 individuals and on the experience of the plans. The experience on the
11 plans shall include data on enrollees in the connector, the operation
12 and administration of the connector premium assistance program,
13 expenses, claims statistics, complaints data, how the connector met its
14 goals, and other information deemed pertinent by the connector; and
15 (2) Any significant observations regarding utilization and adoption
16 of the connector.

17 <u>NEW SECTION.</u> **Sec. 215.** REPORT ON STATE AND SCHOOL EMPLOYEE
18 PARTICIPATION IN THE CONNECTOR. On or before September 1, 2010, the
19 board shall prepare a report and recommendations regarding the
20 participation of active and retired state employees, political
21 subdivision employees, and school employees in the connector. The
22 report shall be submitted to the governor and relevant committees of
23 the legislature. The report shall examine at least the following
24 issues:
25 (1) The impact of active and retired state employees, political
26 subdivision employees, and school employees participating in the
27 connector, with respect to the utilization of services and cost of
28 health plans offered through the connector;
29 (2) Whether any distinction should be made in connector
30 participation between active and retired employees, giving
31 consideration to the implicit subsidy that nonmedicare eligible
32 retirees currently benefit from by being pooled with active employees,
33 and to how medicare-eligible retirees would be affected;
34 (3) The impact of applying the insurance regulations in section 303
35 of this act, RCW 48.43.015, 48.43.025, 48.43.035, and section 307 of
36 this act on access to health services and the cost of coverage for

active and retired state employees, political subdivision employees, and school employees;

(4) Whether the reinsurance program established in section 501 of this act could appreciably lower premium costs if applied to active and retired state employees, political subdivision employees, and school employees participating in the connector; and

(5) If the board recommends participation of any of these employee groups in the connector, how the composition of the board should be modified to reflect their participation.

NEW SECTION. **Sec. 216.** RULES. The administrator may adopt any rules necessary to implement this chapter.

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

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) "Connector" means the Washington state health insurance connector established in sections 203 through 205 of this act.

(9) "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)~~)) (10) "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)~~)) (11) "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

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

8 ((~~(11)~~)) (12) "Eligible individual" means an individual, including
9 a sole proprietor, who is a resident of Washington state who is not
10 offered subsidized health insurance by an employer with more than fifty
11 employees. "Eligible individual" includes any individual who is
12 eligible for benefits under section 210 of the federal trade act of
13 2002, at 26 U.S.C. Sec. 35(c).

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

21 ((~~(12)~~)) (14) "Emergency services" means otherwise covered health
22 care services medically necessary to evaluate and treat an emergency
23 medical condition, provided in a hospital emergency department.

24 ((~~(13)~~)) (15) "Enrollee point-of-service cost-sharing" means
25 amounts paid to health carriers directly providing services, health
26 care providers, or health care facilities by enrollees and may include
27 copayments, coinsurance, or deductibles.

28 ((~~(14)~~)) (16) "Grievance" means a written complaint submitted by or
29 on behalf of a covered person regarding: (a) Denial of payment for
30 medical services or nonprovision of medical services included in the
31 covered person's health benefit plan, or (b) service delivery issues
32 other than denial of payment for medical services or nonprovision of
33 medical services, including dissatisfaction with medical care, waiting
34 time for medical services, provider or staff attitude or demeanor, or
35 dissatisfaction with service provided by the health carrier.

36 ((~~(15)~~)) (17) "Health care facility" or "facility" means hospices
37 licensed under chapter 70.127 RCW, hospitals licensed under chapter
38 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)~~)) (18) "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)~~)) (19) "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)~~)) (20) "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)~~)) (21) "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)~~)) (22) "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)~~)) (23) "Participating individual" means a person who has been determined by the connector to be, and continues to be, an eligible individual, an employee of a participating small employer plan, or a member of an association health plan for purposes of obtaining coverage through the connector. As used in this section, "association health plan" includes health plans offered through associations, trusts, and member-governed groups.

(24) "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 connector, in accordance with the provisions of section 208 of this act, for the connector to offer and administer health insurance benefits for enrollees in the plan.

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

((~~(22)~~)) (26) "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)~~)) (27) "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)~~)) (28) "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)~~)) (29) "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)~~)) (30) "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.** CERTIFICATION OF HEALTH BENEFIT PLANS BY THE OFFICE OF THE INSURANCE COMMISSIONER. (1) Health benefit plans offered through the connector established in section 203 of this act shall be filed with the office of the insurance commissioner.

(2) No health benefit plan may be offered through the connector unless the commissioner has first certified to the connector that:

(a) The carrier seeking to offer the plan is an admitted carrier in Washington state and is in good standing with the office of the insurance commissioner;

(b) The plan meets the benefit design specifications established by the connector board under section 205(1) of this act, the rating specifications under section 303 of this act, the preexisting condition provisions under RCW 48.43.015 and 48.43.025, the issue and renewal provisions of RCW 48.43.035, and the requirements of this section; and

(c) The plan and the carrier are in compliance with all other applicable Washington state laws.

(3) No plan shall be certified that excludes from coverage any individual otherwise determined by the connector as meeting the eligibility requirements for individual or small group participation.

(4) Each certification shall be valid for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence of notice of either:

1 (a) Withdrawal by the commissioner; or
2 (b) Discontinuation of participation in the connector by the
3 carrier.
4 (5) Certification of a plan may be withdrawn only after notice to
5 the carrier and opportunity for hearing. The commissioner may,
6 however, decline to renew the certification of any carrier at the end
7 of a certification term.
8 (6) Each plan certified by the commissioner as eligible to be
9 offered through the connector shall contain a detailed description of
10 benefits offered including maximums, limitations, exclusions, and other
11 benefit limits.

12 NEW SECTION. **Sec. 303.** HEALTH PLAN RATING METHODOLOGY. Premium
13 rates for health benefit plans sold through the connector are subject
14 to the following provisions:
15 (1) The carrier shall develop its rates based on an adjusted
16 community rate and may only vary the adjusted community rate for:
17 (a) Geographic area;
18 (b) Family size;
19 (c) Age; and
20 (d) Wellness activities.
21 (2) The adjustment for age in subsection (1)(c) of this section may
22 not use age brackets smaller than five-year increments, which shall
23 begin with age twenty and end with age sixty-five. Participating
24 individuals under the age of twenty shall be treated as those age
25 twenty.
26 (3) The contractor shall be permitted to develop separate rates for
27 individuals age sixty-five or older for coverage for which medicare is
28 the primary payer and coverage for which medicare is not the primary
29 payer. Both rates are subject to the requirements of this section.
30 (4) The permitted rates for any age group shall be no more than
31 three hundred seventy-five percent of the lowest rate for all age
32 groups.
33 (5) A discount for wellness activities is permitted to reflect
34 actuarially justified differences in utilization or cost attributed to
35 such programs.
36 (6) Rating factors shall produce premiums for identical eligible

individuals that differ only by the amounts attributable to plan design, with the exception of discounts for health improvement programs.

(7)(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 eligible individuals purchasing coverage through the connector.

(b) Carriers may treat persons under age thirty as a separate experience pool for purposes of establishing rates for health plans approved by the connector board under section 205(1)(a) (i) and (ii). The rates charged for this age group are not subject to subsection (4) of this section.

(8) The rates for health plans available to eligible individuals and participating employers who are described in section 501 of this act shall reflect the availability of reimbursement from the reinsurance account.

Sec. 304. 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 or through the connector established in sections 203 through 205 of this act, 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~~)) <u>through the connector established in sections 203 through 205 of this act</u>:

(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)~~)) (3) of this section, nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its existing health plans. In addition, nothing in this section requires a carrier to waive benefit limitations not related to an individual or group's preexisting conditions or health history.

Sec. 305. 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 connector established in sections 203 through 205 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. 306. 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 connector established in sections 203 through 205 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

1 carrier's service area and provide or assure the provision of all
2 covered services regardless of age, sex, family structure, ethnicity,
3 race, health condition, geographic location, employment status,
4 socioeconomic status, other condition or situation, or the provisions
5 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
6 exemption from this subsection, if, upon application by a health
7 carrier the commissioner finds that the clinical, financial, or
8 administrative capacity to serve existing enrollees will be impaired if
9 a health carrier is required to continue enrollment of additional
10 eligible individuals.

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

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

22 (a) Nonpayment of premium;

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

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

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

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

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

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

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

38 (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. 307.** INSURANCE MARKET CONSOLIDATION. (1) A carrier shall not issue or renew an individual health benefit plan, other than through the connector established in section 203 of this act, after January 1, 2009.

(2) A carrier shall not issue or renew a small group health benefit plan, including a plan offered through an association or member-governed group whether or not formed specifically for the purpose of purchasing health care, other than through the connector established in section 203 of this act, after January 1, 2009.

NEW SECTION. **Sec. 308.** RULES. The commissioner may adopt any rules necessary to implement this chapter.

PART IV: INDIVIDUAL AND 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.

1 (3) "Connector" means the entity established in sections 203
2 through 205 of this act.

3 NEW SECTION. **Sec. 402.** Each employer with more than five
4 employees in the state of Washington shall:
5 (1) Adopt and maintain a cafeteria plan that satisfies 26 U.S.C.
6 Sec. 125 and the rules adopted by the connector that provides a premium
7 only plan option so that employees can use salary deductions to pay
8 health plan premiums. A copy of such cafeteria plan shall be filed
9 with the connector; and
10 (2) Collect and transmit amounts designated as payroll deductions
11 by employees to the connector for those employees purchasing coverage
12 through the connector.

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

16 NEW SECTION. **Sec. 404.** Beginning January 1, 2012, any resident of
17 the state of Washington age eighteen and over shall obtain and maintain
18 creditable coverage, as defined in the federal health insurance
19 portability and accountability act of 1996 (42 U.S.C. 300gg(c)), so
20 long as it is deemed affordable under the schedule set by the board of
21 the connector under section 205 of this act. Residents who within the
22 past sixty-three days have terminated any prior creditable coverage,
23 shall obtain and maintain creditable coverage within sixty-three days
24 of such termination.

25 **PART V: REINSURANCE**

26 NEW SECTION. **Sec. 501.** A new section is added to chapter 48.43
27 RCW to read as follows:
28 (1) A reinsurance program is hereby established in the office of
29 the insurance commissioner for the purpose of making health insurance
30 coverage more affordable for eligible individuals and participating
31 small employer plans.
32 (2) The submission of claims for reimbursement is limited to claims
33 paid on behalf of eligible individuals and persons employed by

participating small employers who have not offered a health benefit plan that provides benefits on an expense reimbursed or prepaid basis to their employees during the twelve-month period prior to application for participation in the connector. The commissioner, in cooperation with the connector, shall obtain from the small employer written certification at the time of initial application to participate in the connector that such employer has not offered a health benefit plan that provides health benefits to its employees during the twelve-month period prior to application for participation in the connector. Submission of claims for reimbursement paid on behalf of persons employed by participating small employers is limited to two years from the date upon which the employer begins participation in the connector.

NEW SECTION. **Sec. 502.** A new section is added to chapter 48.43 RCW to read as follows:

Beginning January 1, 2009, carriers shall be eligible to receive reimbursement for ninety percent of claims paid between thirty thousand and one hundred thousand dollars in a calendar year for any enrollee described in section 501 of this act who is covered under a health plan offered by the carrier through the connector.

(1) Claims shall be reported and funds shall be distributed from the reinsurance account on a calendar year basis. Claims are eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of an enrollee described in section 501 of this act reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such person in that calendar year are eligible for reimbursement.

(2) Each carrier shall submit a request for reimbursement from the reinsurance account on forms prescribed by the commissioner. Each of the requests for reimbursement shall be submitted no later than April 1st following the end of the calendar year for which the reimbursement requests are being made. The commissioner may require carriers to submit such claims data in connection with the reimbursement requests as he or she deems necessary to enable distribution of funds and oversee the operation of the reinsurance account.

(3) The commissioner shall calculate the total claims reimbursement amount for all carriers for the calendar year for which claims are being reported.

1 (a) In the event that the total amount requested for reimbursement
2 for a calendar year exceeds funds available for distribution for claims
3 paid during that same calendar year, the commissioner shall provide for
4 the pro rata distribution of the available funds. Each carrier is
5 eligible to receive only such proportionate amount of the available
6 funds as the individual carrier's total eligible claims paid bears to
7 the total eligible claims paid by all carriers.
8 (b) In the event that funds available for distribution for claims
9 paid by all carriers during a calendar year exceeds the total amount
10 requested for reimbursement by all carriers during that same calendar
11 year, any excess funds shall be carried forward and made available for
12 distribution in the next calendar year. Such excess funds shall be in
13 addition to the funds appropriated for the reinsurance account in the
14 next calendar year.

15 NEW SECTION. **Sec. 503.** A new section is added to chapter 48.43
16 RCW to read as follows:
17 The reinsurance account is created in the custody of the state
18 treasurer. All appropriations for the reinsurance program must be
19 deposited in the account. Expenditures from the account may be used
20 only for the purposes of section 502 of this act, including the
21 reimbursement paid to carriers and the associated administrative
22 expenses of operating the reinsurance program. Only the commissioner
23 or the commissioner's designee may authorize expenditures from the
24 account. The account is subject to allotment procedures under chapter
25 43.88 RCW, but an appropriation is not required for expenditures.

26 NEW SECTION. **Sec. 504.** A new section is added to chapter 48.43
27 RCW to read as follows:
28 If the commissioner deems it appropriate for the proper
29 administration of the reinsurance account, the commissioner or the
30 administrator of the account, on behalf of and with the prior approval
31 of the commissioner, may purchase stop loss insurance or reinsurance
32 from an insurance company licensed to write such type of insurance in
33 this state. Such stop loss insurance or reinsurance may be purchased
34 with funds appropriated to the reinsurance account established in
35 section 503 of this act.

1 NEW SECTION. **Sec. 505.** A new section is added to chapter 48.43
2 RCW to read as follows:
3 Upon the request of the commissioner, each carrier shall furnish
4 such data as the commissioner deems necessary to oversee the operation
5 of the reinsurance account. The commissioner shall adopt rules that
6 set forth procedures for the operation of the reinsurance account and
7 distribution of funds therefrom.

8 **PART VI: CONFORMING AMENDMENTS, REPEALERS, AND**
9 **EFFECTIVE DATES**

10 NEW SECTION. **Sec. 601.** (1) Sections 102, 201, and 203 through 216
11 of this act constitute a new chapter in Title 41 RCW.
12 (2) Sections 302, 303, 307, and 308 of this act are each added to
13 chapter 48.43 RCW.
14 (3) Sections 401 through 404 of this act constitute a new chapter
15 in Title 49 RCW.

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

18 NEW SECTION. **Sec. 603.** The following acts or parts of acts are
19 each repealed, effective January 1, 2009:
20 (1) RCW 48.01.260 (Health benefit plans--Carriers--Clarification)
21 and 2000 c 79 s 40;
22 (2) RCW 48.20.025 (Schedule of rates for individual health benefit
23 plans--Loss ratio--Remittance of premiums--Definitions) and 2003 c 248
24 s 8, 2001 c 196 s 1, & 2000 c 79 s 3;
25 (3) RCW 48.20.028 (Calculation of premiums--Adjusted community
26 rating method--Definitions) and 2006 c 100 s 1, 2000 c 79 s 4, 1997 c
27 231 s 207, & 1995 c 265 s 13;
28 (4) RCW 48.20.029 (Calculation of premiums--Members of a purchasing
29 pool--Adjusted community rating method--Definitions) and 2006 c 100 s
30 2;
31 (5) RCW 48.21.045 (Health plan benefits for small employers--
32 Coverage--Exemption from statutory requirements--Premium rates--
33 Requirements for providing coverage for small employers--Definitions)
34 and 2004 c 244 s 1, 1995 c 265 s 14, & 1990 c 187 s 2;

1 (6) RCW 48.21.047 (Requirements for plans offered to small
2 employers--Definitions) and 2005 c 223 s 11 & 1995 c 265 s 22;
3 (7) RCW 48.43.012 (Individual health benefit plans--Preexisting
4 conditions) and 2001 c 196 s 6 & 2000 c 79 s 19;
5 (8) RCW 48.43.018 (Requirement to complete the standard health
6 questionnaire--Exemptions--Results) and 2004 c 244 s 3, 2001 c 196 s 8,
7 2000 c 80 s 4, & 2000 c 79 s 21;
8 (9) RCW 48.43.038 (Individual health plans--Guarantee of continuity
9 of coverage--Exceptions) and 2000 c 79 s 25;
10 (10) RCW 48.43.041 (Individual health benefit plans--Mandatory
11 benefits) and 2000 c 79 s 26;
12 (11) RCW 48.44.017 (Schedule of rates for individual contracts--
13 Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 11 &
14 2000 c 79 s 29;
15 (12) RCW 48.44.021 (Calculation of premiums--Members of a
16 purchasing pool--Adjusted community rating method--Definitions) and
17 2006 c 100 s 4;
18 (13) RCW 48.44.022 (Calculation of premiums--Adjusted community
19 rate--Definitions) and 2006 c 100 s 3, 2004 c 244 s 6, 2000 c 79 s 30,
20 1997 c 231 s 208, & 1995 c 265 s 15;
21 (14) RCW 48.44.023 (Health plan benefits for small employers--
22 Coverage--Exemption from statutory requirements--Premium rates--
23 Requirements for providing coverage for small employers) and 2004 c 244
24 s 7, 1995 c 265 s 16, & 1990 c 187 s 3;
25 (15) RCW 48.44.024 (Requirements for plans offered to small
26 employers--Definitions) and 2003 c 248 s 15 & 1995 c 265 s 23;
27 (16) RCW 48.46.062 (Schedule of rates for individual agreements--
28 Loss ratio--Remittance of premiums--Definitions) and 2001 c 196 s 12 &
29 2000 c 79 s 32;
30 (17) RCW 48.46.063 (Calculation of premiums--Members of a
31 purchasing pool--Adjusted community rating method--Definitions) and
32 2006 c 100 s 6;
33 (18) RCW 48.46.064 (Calculation of premiums--Adjusted community
34 rate--Definitions) and 2006 c 100 s 5, 2004 c 244 s 8, 2000 c 79 s 33,
35 1997 c 231 s 209, & 1995 c 265 s 17;
36 (19) RCW 48.46.066 (Health plan benefits for small employers--
37 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;

(20) RCW 48.46.068 (Requirements for plans offered to small employers--Definitions) and 2003 c 248 s 16 & 1995 c 265 s 24;

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 604.** The following acts or parts of acts are each repealed, effective January 1, 2010:

(1) RCW 48.41.010 (Short title) and 1987 c 431 s 1;

(2) RCW 48.41.020 (Intent) and 2000 c 79 s 5 & 1987 c 431 s 2;

(3) RCW 48.41.030 (Definitions) and 2004 c 260 s 25, 2001 c 196 s 2, 2000 c 79 s 6, 1997 c 337 s 6, 1997 c 231 s 210, 1989 c 121 s 1, & 1987 c 431 s 3;

(4) RCW 48.41.037 (Washington state health insurance pool account) and 2000 c 79 s 36;

(5) RCW 48.41.040 (Health insurance pool--Creation, membership, organization, operation, rules) and 2000 c 80 s 1, 2000 c 79 s 7, 1989 c 121 s 2, & 1987 c 431 s 4;

(6) RCW 48.41.050 (Operation plan--Contents) and 1987 c 431 s 5;

(7) RCW 48.41.060 (Board powers and duties) and 2005 c 7 s 2, 2004 c 260 s 26, 2000 c 79 s 9, 1997 c 337 s 5, 1997 c 231 s 211, 1989 c 121 s 3, & 1987 c 431 s 6;

1 (8) RCW 48.41.070 (Examination and report) and 1998 c 245 s 98,
2 1989 c 121 s 4, & 1987 c 431 s 7;
3 (9) RCW 48.41.080 (Pool administrator--Selection, term, duties,
4 pay) and 2000 c 79 s 10, 1997 c 231 s 212, 1989 c 121 s 5, & 1987 c 431
5 s 8;
6 (10) RCW 48.41.090 (Financial participation in pool--Computation,
7 deficit assessments) and 2005 c 405 s 2, 2000 c 79 s 11, 1989 c 121 s
8 6, & 1987 c 431 s 9;
9 (11) RCW 48.41.100 (Eligibility for coverage) and 2001 c 196 s 3,
10 2000 c 79 s 12, 1995 c 34 s 5, 1989 c 121 s 7, & 1987 c 431 s 10;
11 (12) RCW 48.41.110 (Policy coverage--Eligible expenses, cost
12 containment, limits--Explanatory brochure) and 2001 c 196 s 4, 2000 c
13 80 s 2, 2000 c 79 s 13, 1997 c 231 s 213, & 1987 c 431 s 11;
14 (13) RCW 48.41.120 (Deductibles--Coinsurance--Carryover) and 2000
15 c 79 s 14, 1989 c 121 s 8, & 1987 c 431 s 12;
16 (14) RCW 48.41.130 (Policy forms--Approval required) and 2000 c 79
17 s 15, 1997 c 231 s 215, & 1987 c 431 s 13;
18 (15) RCW 48.41.140 (Coverage for children, unmarried dependents)
19 and 2000 c 79 s 16 & 1987 c 431 s 14;
20 (16) RCW 48.41.150 (Medical supplement policy) and 1989 c 121 s 9
21 & 1987 c 431 s 15;
22 (17) RCW 48.41.160 (Renewal, termination, dependents' coverage--
23 Rate changes--Continuation) and 1987 c 431 s 16;
24 (18) RCW 48.41.170 (Required rule making) and 1987 c 431 s 17;
25 (19) RCW 48.41.190 (Civil and criminal immunity) and 1989 c 121 s
26 10 & 1987 c 431 s 19;
27 (20) RCW 48.41.200 (Rates--Standard risk and maximum) and 2000 c 79
28 s 17, 1997 c 231 s 214, & 1987 c 431 s 20;
29 (21) RCW 48.41.210 (Last payor of benefits) and 1987 c 431 s 21;
30 (22) RCW 48.41.900 (Federal supremacy) and 1987 c 431 s 22; and
31 (23) RCW 48.41.910 (Severability--1987 c 431) and 1987 c 431 s 25.

32 NEW SECTION. **Sec. 605.** Sections 304 through 306 of this act take
33 effect January 1, 2009.

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