H-1454.2

# HOUSE BILL 2174

**State of Washington 61st Legislature 2009 Regular Session**

**By** Representatives Eddy, Seaquist, Ericksen, Hinkle, Takko, Herrera, Sullivan, Pettigrew, Springer, Blake, Wallace, and Ericks

Read first time 02/11/09. Referred to Committee on Health Care & Wellness.

AN ACT Relating to health care; amending RCW 48.05.010, 48.43.041, 48.44.022, 48.46.064, 48.20.029, 70.47.060, 48.21.045, and 48.44.023; adding new sections to chapter 48.05 RCW; adding a new section to chapter 48.43 RCW; adding new sections to chapter 70.41 RCW; adding a new section to chapter 70.02 RCW; adding a new section to chapter 70.01 RCW; adding a new section to chapter 70.14 RCW; and creating new sections.

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

## PART I. SHORT TITLE

NEW SECTION. **Sec. 101.** SHORT TITLE. This act may be known and cited as the "Comprehensive Health Options, Incentives, and Consumer Empowerment Act" or "CHOICE Act."

## PART II. LEGISLATIVE FINDINGS

NEW SECTION. **Sec. 201.** LEGISLATIVE FINDINGS. The legislature finds that:

(1) Health care costs are expected to grow by 9.6 percent in 2009, after experiencing a projected 9.9 percent growth in 2008. As health care costs continue to rise, employers, families, and individuals are looking for solutions that will restore the affordability of health care premiums and increase access to desired coverage.

(2) Recommendation number eight of the 2006 governor's blue ribbon commission on health care costs and access recommended giving individuals and families more choice in selecting the private insurance plans that work for them, but this recommendation has yet to be acted upon by the legislature.

(3) Although only twelve percent of the state's uninsured population are those employed by a company that does not offer health insurance, as costs continue to rise, employers with few choices for providing low-cost coverage may soon be forced to drop coverage due to cost, adding to the ranks of uninsured persons in Washington.

(4) Young adults comprise nearly forty-four percent of the uninsured population, yet they are also in the lowest range of their earning potential. More affordable health care coverage is necessary to ensure that these individuals are able to purchase the basic coverage they need.

(5) More than a quarter of all uninsured individuals work for employers that offer insurance coverage, but the individual is either ineligible to participate in coverage sponsored by his or her employer or cannot afford the cost-sharing requirements necessary to participate in the employer's health plan.

(6) Perpetual changes in the health insurance market over the past fifteen years have created uncertainty and an overly burdensome regulatory environment for insurers, driving many from Washington and discouraging others from joining the market. This lack of insurer competition in Washington artificially inflates health care premium rates and stifles the innovation necessary to address consumer needs.

(7) Empowering consumers with information regarding the cost and quality of health care services will return control of health care decisions to consumers who are in the best position to make decisions regarding the care they need or desire.

(8) The state should provide a safety net to assist low-income individuals who are unable to access or purchase coverage on their own.

## PART III. INCREASING THE AVAILABILITY OF AFFORDABLE COVERAGE

**Sec. 301.** RCW 48.05.010 and 1961 c 194 s 1 are each amended to read as follows:

(1) A "domestic" insurer is one formed under the laws of this state.

(2) A "foreign" insurer is one formed under the laws of the United States, of a state or territory of the United States other than this state, or of the District of Columbia.

(3) A "foreign health insurer" is one formed under the laws of the United States, of a state or territory of the United States other than this state, or of the District of Columbia, that provides health benefit coverage as described in RCW 48.21.010 or 48.43.005(19).

(4) An "alien" insurer is one formed under the laws of a nation other than the United States.

((~~(4)~~)) (5) For the purposes of this code, "United States," when used to signify place, means only the states of the United States, the government of Puerto Rico and the District of Columbia.

NEW SECTION. **Sec. 302.** A new section is added to chapter 48.05 RCW to read as follows:

(1) A foreign health insurer may apply for a certificate of authority to offer and provide health benefit plans to residents in this state, using a form prescribed by the commissioner. Upon application, the commissioner shall issue a certificate of authority to the foreign health insurer unless the commissioner determines that the insurer:

(a) Will not provide health insurance services in compliance with the provisions of this chapter;

(b) Is in a hazardous financial condition, as determined by an examination by the commissioner conducted in accordance with the financial analysis handbook of the national association of insurance commissioners; or

(c) Has not adopted procedures to ensure compliance with all applicable federal and state laws governing the confidentiality of its records with respect to providers and covered persons.

(2) Prior to the issuance of a certificate of authority, a foreign health insurer must file with the commissioner a certificate from the public official having supervision over the insurer in its domiciliary

state to the effect that a deposit in equal or greater amount is held in public custody in such state for the protection of all its policyholders, or of all of its policyholders and obligees within the United States, in amount and kind, subject to RCW 48.14.040, the same as is required of a like domestic insurer transacting like kinds of insurance. The commissioner may require the foreign health insurer to annually file such a certificate.

(3) A certificate of authority issued pursuant to this section shall be valid for three years from the date of issuance by the commissioner.

(4) The commissioner shall establish by rule:

(a) Procedures for a foreign health insurer to renew a certificate of authority, pursuant to and consistent with the provisions of this chapter; and

(b) A certificate of authority application and renewal fees, the amount of which shall be no greater than is reasonably necessary to enable the office to carry out the provisions of this chapter.

(5) The coverage provided by a foreign health insurer is subject to the provisions of RCW 48.43.022, 48.43.500 through 48.43.535, 48.43.545, and 48.43.550.

(a) Persons appointed or authorized to solicit applications for enrollment must comply with chapter 48.17 RCW.

(b) Foreign health insurers must comply with RCW 48.14.0201.

NEW SECTION. **Sec. 303.** A new section is added to chapter 48.05 RCW to read as follows:

(1) The commissioner may deny, revoke, or suspend, after notice and opportunity to be heard, a certificate of authority issued to a foreign health carrier pursuant to this chapter for a violation of the provisions of this chapter, including any finding by the commissioner that a foreign health carrier is no longer in compliance with any of the conditions for issuance of a certificate of authority set forth in section 302(1) of this act, or the rules adopted pursuant to this chapter. The commissioner shall provide for an appropriate and timely right of appeal for the foreign health carrier whose certificate is denied, revoked, or suspended.

(2) The commissioner shall establish grievance and independent

claims review procedures with respect to claims by a health care provider or a covered person with which a foreign health insurer shall comply as a condition of issuing policies in this state.

(3)(a) The commissioner shall establish fair marketing standards for marketing materials used by foreign health insurers to market individual health benefits plans to residents in this state.

(b) The commissioner shall establish fair marketing standards for marketing materials used by foreign health insurers to market small employer health benefits plans to small employers in this state.

(4) The procedures and standards established under subsections (2) and (3) of this section shall be applied on a nondiscriminatory basis so as not to place greater responsibilities on foreign health insurers than the responsibilities placed on other health carriers doing business in this state.

NEW SECTION. **Sec. 304.** A new section is added to chapter 48.05 RCW to read as follows:

A domestic carrier authorized to do business in this state may apply to the commissioner for an exemption from the provisions of this title and any rules promulgated under those provisions, that would allow the domestic carrier to offer health care plans that are comparable in plan design to health care plans offered by foreign health insurers under this chapter. Upon a domestic carrier's application, the commissioner shall make an order exempting the domestic carrier from those provisions and rules in order to allow the domestic carrier to offer a health care plan or plans that are comparable in design to health care plans offered by foreign health insurers under this chapter. Any health care plan offer by a domestic carrier under an exemption under this section shall be subject to the requirements that apply to health care plans offered by foreign health insurers under this chapter.

NEW SECTION. **Sec. 305.** A new section is added to chapter 48.05 RCW to read as follows:

The office shall adopt rules to effectuate the purposes of this chapter, provided, however, that the rules shall not:

(1) Directly or indirectly require a foreign health insurer to,

directly or indirectly, modify coverage or benefit requirements, or restrict underwriting requirements or premium ratings, in any way that conflicts with the carrier's domiciliary state's laws or rules;

(2) Provide for requirements that are more stringent than those applicable to carriers that are licensed by the commissioner to provide health benefits plans in this state; or

(3) Require any individual health benefits plan or small employer health benefits plan issued by the foreign health insurer to be countersigned by an insurance agent or broker residing in this state.

**Sec. 306.** RCW 48.43.041 and 2000 c 79 s 26 are each amended to read as follows:

(1) All individual health benefit plans, other than catastrophic health plans((~~, offered or renewed on or after October 1, 2000~~)) and plans for young adults described in subsection (3) of this section, shall include benefits described in this section. Nothing in this section shall be construed to require a carrier to offer an individual health benefit plan.

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

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

(2) If a carrier offers a health benefit plan that is not a catastrophic health plan to groups, and it chooses to offer a health benefit plan to individuals, it must offer at least one health benefit plan to individuals that is not a catastrophic health plan.

(3) Carriers may design and offer a separate health plan targeted at young adults between nineteen and thirty-four years of age. The plan may include the benefits required under subsections (1) and (2) of this section but is not required to include these benefits. The health plan designed for young adults is exempt from the requirements of RCW 48.43.045(1), 48.43.515(5), 48.44.327, 48.20.392, 48.46.277, 48.43.043, 48.20.580, 48.21.241, 48.44.341, and 48.46.291. Carriers who choose to

exclude maternity services from a young adult plan offered under this section must allow enrollees who become pregnant to transfer to another health benefit plan with similar cost-sharing provisions that provides coverage for maternity services, once pregnancy is confirmed by a licensed provider. Carriers shall allow the transfer to occur without applying a preexisting condition waiting period or other limitation or penalty including, but not limited to, satisfying a new deductible or stop-loss requirement.

**Sec. 307.** RCW 48.44.022 and 2006 c 100 s 3 are each amended to read as follows:

(1) Except for health benefit plans covered under RCW 48.44.021, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health care service contractor shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health care service contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) Except as provided in subsection (2) of this section, the permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to

reflect actuarially justified differences in utilization or cost attributed to such programs.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.44.021, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.44.023. Carriers may treat young adults and products developed specifically for them consistent with RCW 48.43.041(3) as a single-banded experience pool for purposes of establishing rates. The rates established for this age group are not subject to subsection (1)(d) of this section.

(3) As used in this section and RCW 48.44.023 "health benefit plan," "small employer," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

**Sec. 308.** RCW 48.46.064 and 2006 c 100 s 5 are each amended to read as follows:

(1) Except for health benefit plans covered under RCW 48.46.063, premium rates for health benefit plans for individuals shall be subject to the following provisions:

(a) The health maintenance organization shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The health maintenance organization shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) Except as provided in subsection (2) of this section, the permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

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

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network

providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, except individuals purchasing coverage under RCW 48.46.063, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.46.066. Carriers may treat young adults and products developed specifically for them consistent with RCW 48.43.041(3) as a single-banded experience pool for purposes of establishing rates. The rates established for this age group are not subject to subsection (1)(d) of this section.

(3) As used in this section and RCW 48.46.066, "health benefit plan," "adjusted community rate," "small employer," and "wellness activities" mean the same as defined in RCW 48.43.005.

**Sec. 309.** RCW 48.20.029 and 2006 c 100 s 2 are each amended to read as follows:

(1) Premiums for health benefit plans for individuals who purchase the plan as a member of a purchasing pool:

(a) Consisting of five hundred or more individuals affiliated with a particular industry;

(b) To whom care management services are provided as a benefit of pool membership; and

(c) Which allows contributions from more than one employer to be used towards the purchase of an individual's health benefit plan;

shall be calculated using the adjusted community rating method that spreads financial risk across the entire purchasing pool of which the individual is a member. All such rates shall conform to the following:

(i) The insurer 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;

(D) Tenure discounts; and

(E) Wellness activities.

(ii) The adjustment for age in (c)(i)(C) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

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

(iv) Except as provided in subsection (2) of this section, the permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(v) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(vi) 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:

(A) Changes to the family composition;

(B) Changes to the health benefit plan requested by the individual; or

(C) Changes in government requirements affecting the health benefit plan.

(vii) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(viii) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(2) Adjusted community rates established under this section shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045. Carriers may treat young adults and products developed specifically for them

consistent with RCW 48.43.041(3) as a single-banded experience pool for purposes of establishing rates. The rates established for this age group are not subject to subsection (1)(c)(iv) of this section.

(3) As used in this section, "health benefit plan," "adjusted community rates," and "wellness activities" mean the same as defined in RCW 48.43.005.

NEW SECTION. **Sec. 310.** A new section is added to chapter 48.43 RCW to read as follows:

The office of the insurance commissioner shall make available educational and outreach materials targeted to young adults aged nineteen to thirty-four, as funding becomes available. Education and outreach efforts shall focus on educating young consumers on the importance and value of health insurance, including educational materials, public service messages, and other outreach activities. The commissioner is authorized to fund these activities with grants, donations, in-kind contributions, or other funding that may be available.

## PART IV. ALLOWING CONSUMERS TO PURCHASE PLANS FROM INSURERS LICENSED OR CERTIFIED OUTSIDE WASHINGTON

NEW SECTION. **Sec. 401.** (1) Beginning January 1, 2010, the office of the insurance commissioner shall allow the sale and acceptance of health insurance plans from insurers licensed or certified in a state other than Washington, in accordance with the following:

(a) The insurer offers the same individual or group health benefit plan in its domiciliary state and is in compliance with all applicable laws, regulations, and other requirements within the domiciliary state;

(b) The insurer is in good standing with the insurance regulator of the insurer's domiciliary state; and

(c) The regulator in the domiciliary state certifies that in the regulator's judgment the insurer has reserves sufficient to support claim demands from anticipated additional enrollment and that the carrier has met the national association of insurance commissioners' solvency standards.

(2) An insurer licensed or certified outside of Washington that is contacted to provide coverage to an individual or small employer in

Washington and is interested in providing health care coverage under this section shall notify the office of the insurance commissioner of its intent to provide such coverage. Within thirty days of notifying the commissioner of the insurer's intent to provide such coverage, the insurer shall provide the commissioner with documentation confirming compliance with subsection (1) of this section. Unless both parties otherwise agree, the commissioner shall have thirty days to review the information provided by the insurer and may only disallow the provision of coverage if the insurer fails to meet one of the criteria identified in subsection (1) of this section.

NEW SECTION. **Sec. 402.** When contacted by a Washington resident regarding a health benefit plan, an insurer licensed or certified outside of Washington shall provide written disclosure of the differences between the covered health benefits the selected benefit plan contains and those required in Washington health benefit plans. Each written application for participation in a benefit plan offered by an insurer not licensed or certified in Washington shall include disclosure language that clearly identifies which, if any, coverage mandates required under Washington law are not contained in the selected policy.

NEW SECTION. **Sec. 403.** The office of the insurance commissioner may adopt rules to specify the format insurers must use to submit the information required in sections 401 and 402 of this act. The commissioner may not develop any rule that:

(1) Either directly or indirectly requires an insurer licensed or certified outside of Washington to modify coverage or benefit requirements including, but not limited to, mandated benefits, provider network, or provider reimbursement requirements, or restricts underwriting requirements or premium ratings, in any way that conflicts with the insurer's domiciliary state's laws, rules, or regulations;

(2) Provides for regulatory requirements that are more stringent than those applicable to insurers that are licensed in the state of Washington; or

(3) Requires any individual health benefit plan or small employer health benefit plan issued by an insurer licensed or certified outside

of Washington to be countersigned by an agent or broker residing in Washington.

NEW SECTION. **Sec. 404.** All complaints against an insurer licensed or certified outside of Washington shall be submitted to the office of the insurance commissioner. The office of the insurance commissioner shall either act in accordance with an existing reciprocity agreement between the domiciliary state in which the insurer is licensed to resolve the complaint or, in circumstances in which no reciprocity agreement exists with the domiciliary state, work directly with the insurance regulator of that state to resolve the complaint.

## PART V. ENCOURAGING ALTERNATIVES TO THE BASIC HEALTH PLAN

**Sec. 501.** RCW 70.47.060 and 2007 c 259 s 36 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order

to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.47.030, and such other factors as the administrator deems appropriate.

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

(b) To determine the periodic premiums due the administrator from subsidized enrollees under RCW 70.47.020(6)(b). Premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level shall be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level shall not exceed one hundred dollars per month.

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

(d) To determine the periodic premiums due the administrator from health coverage tax credit eligible enrollees. Premiums due from health coverage tax credit eligible enrollees must be in an amount equal to the cost charged by the managed health care system provider to

the state for the plan, plus the administrative cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201. The administrator will consider the impact of eligibility determination by the appropriate federal agency designated by the Trade Act of 2002 (P.L. 107-210) as well as the premium collection and remittance activities by the United States internal revenue service when determining the administrative cost charged for health coverage tax credit eligible enrollees.

(e) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator. The administrator shall establish a mechanism for receiving premium payments from the United States internal revenue service for health coverage tax credit eligible enrollees.

(f) Beginning July 1, 2009, the administrator shall identify basic health plan enrollees that have access to employer-sponsored coverage and prepare for the transition of those enrollees to the employer-sponsored plans during the next available open enrollment period of the employer-sponsored plan. The administrator may provide an amount equivalent to the subsidy otherwise available through the basic health plan to the employer to pay for any cost-sharing requirements prohibiting the enrollee's participation in the employer-sponsored plan.

(g) Beginning July 1, 2009, the administrator shall offer premium subsidies equivalent to the subsidy otherwise available through the basic health plan to any basic health plan enrollee interested in moving to the individual insurance market, provided the premium cost for the individual plan selected does not exceed that of the premium paid for coverage in the basic health plan.

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

(3) To evaluate, with the cooperation of participating managed health care system providers, the impact on the basic health plan of enrolling health coverage tax credit eligible enrollees. The administrator shall issue to the appropriate committees of the

legislature preliminary evaluations on June 1, 2005, and January 1, 2006, and a final evaluation by June 1, 2006. The evaluation shall address the number of persons enrolled, the duration of their enrollment, their utilization of covered services relative to other basic health plan enrollees, and the extent to which their enrollment contributed to any change in the cost of the basic health plan.

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

(5) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, nonsubsidized, and health coverage tax credit eligible enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(6) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

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

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

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

enrollees. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(10) To receive periodic premiums from or on behalf of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(11) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized, nonsubsidized, or health coverage tax credit eligible enrollees, to give priority to members of the Washington national guard and reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents, for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid

by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

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

(13) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same or actuarially equivalent for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator

shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

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

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

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

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

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

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

(20) To give priority in enrollment to persons who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

## PART VI. TRANSPARENCY OF HEALTH CARE COSTS

NEW SECTION. **Sec. 601.** A new section is added to chapter 70.41 RCW to read as follows:

(1) All hospitals licensed pursuant to this chapter and ambulatory surgical centers licensed pursuant to chapter 70.230 RCW shall report annually to the Washington state department of health the charge information for that hospital's all patient refined diagnosis-related groups for which that hospital had at least ten cases during the twelve months preceding the report. The charge information for this section shall include the number of discharges; average length of stay; average charge; median charge; demographic information; payer mix; charges paid and not paid by medicare, medicaid, other government programs, individuals, and private insurance; and uncompensated care.

(2) To the extent possible, the department of health shall use existing information received from hospitals to fulfill this requirement. The department may promulgate rules pursuant to this section to standardize the reporting of the required charge information from hospitals. The rules must include:

(a) The method for hospitals to report charges; and

(b) Standards that provide for the validity and comparability of charge reports.

NEW SECTION. **Sec. 602.** A new section is added to chapter 70.41 RCW to read as follows:

By December 1, 2009, the department of health shall report the information gathered under section 601 of this act to the public at no cost through its web site. The charge information posted on the web site must include disclaimers of factors such as case severity ratings and individual patient variations, which may affect actual charges to a patient for services rendered. The web site posting shall organize the information provided to include comparisons of hospital-specific data to hospital statewide data. The web site posting must be made available by June 1, 2010, and must be updated at least annually.

NEW SECTION. **Sec. 603.** A new section is added to chapter 70.02 RCW to read as follows:

(1) Any licensed health care facility or any practitioner of the healing arts, including a physician, dentist, optometrist, podiatrist,

chiropractor, physical therapist, respiratory care practitioner, occupational therapist, or psychologist, shall post in a conspicuous place the following invitation to discuss fees or charges: SHOULD ANY PATIENT WISH TO DISCUSS FEES OR CHARGES, YOU ARE ENCOURAGED TO ASK ABOUT THEM. For the purposes of this section, conspicuous place is an openly visible location in a waiting room, reception area, admission room, or other area where the patient can readily observe the posting. If the health care provider does not have an area suitable for posting, the provider shall furnish the same information in writing to each patient.

(2) If a patient requests information about fees and charges from a health care provider or a health care facility, then the health care provider or health care facility must provide the information requested and may refer the patient to his or her insurer for information about his or her insurance coverage and personal responsibility for payment under a specific insurance plan.

(3) Failure to comply with the provisions of this section shall be grounds for disciplinary action on behalf of the appropriate licensing authority.

NEW SECTION. **Sec. 604.** A new section is added to chapter 70.01 RCW to read as follows:

(1) All fees and charges for health care services and procedures shall be disclosed by a health care provider licensed under Title 18 RCW or facility licensed under Title 70 RCW, upon request of a patient.

(2) Providers may, after disclosing charges and fees to a patient, refer the patient to the patient's insurer for specific information on the insurer's negotiated charges and fees for services and procedures, and any cost-sharing responsibilities required of the patient.

## PART VII.
## IMPROVING EMPLOYEE WELLNESS

**Sec. 701.** RCW 48.21.045 and 2008 c 143 s 6 are each amended to read as follows:

(1)(a) An insurer offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care,

may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude an insurer from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. An insurer 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 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, 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320.

(2) Nothing in this section shall prohibit an insurer 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 thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary

payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers must consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

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

(h) 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.

(i) Adjusted community rates established under this section shall pool the medical experience of all small groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group 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 small group benefit plans will have a revenue neutral effect on the carrier's small group 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.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(4) Nothing in this section shall restrict the right of employees

to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by an insurer in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) An insurer shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) An insurer may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) An insurer must offer coverage to all eligible employees of a small employer and their dependents. An insurer may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. An insurer may not modify a health plan with respect to a small employer or any eligible employee 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.

(7) As used in this section, "health benefit plan," "small employer," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005.

**Sec. 702.** RCW 48.44.023 and 2008 c 143 s 7 are each amended to read as follows:

(1)(a) A health care services contractor offering any health benefit plan to a small employer, either directly or through an association or member-governed group formed specifically for the purpose of purchasing health care, may offer and actively market to the small employer a health benefit plan featuring a limited schedule of covered health care services. Nothing in this subsection shall preclude a contractor from offering, or a small employer from purchasing, other health benefit plans that may have more comprehensive benefits than those included in the product offered under this subsection. A contractor 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 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, 48.44.344, 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460.

(2) Nothing in this section shall prohibit a health care service contractor 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 thereto.

(3) Premium rates for health benefit plans for small employers as defined in this section shall be subject to the following provisions:

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

(i) Geographic area;

(ii) Family size;

(iii) Age; and

(iv) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments, which shall begin

with age twenty and end with age sixty-five. Employees under the age of twenty shall be treated as those age twenty.

(c) The contractor shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection (3).

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs. Up to a twenty percent variance may be allowed for small employers that develop and implement a wellness program or activities that directly improve employee wellness. Employers shall document program activities with the carrier and may after three years of implementation, request a reduction in premiums based on improved employee health and wellness. While carriers may review the employer's claim history when making a determination regarding whether the employer's wellness program has improved employee health, the carrier may not use maternity or prevention services claims to deny the employer's request. Carriers must consider issues such as improved productivity or a reduction in absenteeism due to illness if submitted by the employer for consideration. Interested employers may also work with the carrier to develop a wellness program and a means to track improved employee health.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the enrollment of the small employer;

(ii) Changes to the family composition of the employee;

(iii) Changes to the health benefit plan requested by the small employer; or

(iv) Changes in government requirements affecting the health benefit plan.

(g) Rating factors shall produce premiums for identical groups that

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

(h) 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.

(i) Adjusted community rates established under this section shall pool the medical experience of all groups purchasing coverage, including the small group participants in the health insurance partnership established in RCW 70.47A.030. However, annual rate adjustments for each small group health benefit plan may vary by up to plus or minus four percentage points from the overall adjustment of a carrier's entire small group 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 small group benefit plans will have a revenue neutral effect on the carrier's small group 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.

(j) For health benefit plans purchased through the health insurance partnership established in chapter 70.47A RCW:

(i) Any surcharge established pursuant to RCW 70.47A.030(2)(e) shall be applied only to health benefit plans purchased through the health insurance partnership; and

(ii) Risk adjustment or reinsurance mechanisms may be used by the health insurance partnership program to redistribute funds to carriers participating in the health insurance partnership based on differences

in risk attributable to individual choice of health plans or other factors unique to health insurance partnership participation. Use of such mechanisms shall be limited to the partnership program and will not affect small group health plans offered outside the partnership.

(4) Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(5)(a) Except as provided in this subsection, requirements used by a contractor in determining whether to provide coverage to a small employer shall be applied uniformly among all small employers applying for coverage or receiving coverage from the carrier.

(b) A contractor shall not require a minimum participation level greater than:

(i) One hundred percent of eligible employees working for groups with three or less employees; and

(ii) Seventy-five percent of eligible employees working for groups with more than three employees.

(c) In applying minimum participation requirements with respect to a small employer, a small employer shall not consider employees or dependents who have similar existing coverage in determining whether the applicable percentage of participation is met.

(d) A contractor may not increase any requirement for minimum employee participation or modify any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage.

(e) Minimum participation requirements and employer premium contribution requirements adopted by the health insurance partnership board under RCW 70.47A.110 shall apply only to the employers and employees who purchase health benefit plans through the health insurance partnership.

(6) A contractor must offer coverage to all eligible employees of a small employer and their dependents. A contractor may not offer coverage to only certain individuals or dependents in a small employer group or to only part of the group. A contractor may not modify a health plan with respect to a small employer or any eligible employee 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.

NEW SECTION. **Sec. 703.** A new section is added to chapter 70.14 RCW to read as follows:

Any group or individual that seeks a new or modified health insurance mandate shall submit a proposal to the health technology clinical committee established under RCW 70.14.090 no later than June 30th of each year. The health technology clinical committee shall review all requests for new or modified health insurance mandates and report its findings and recommendations to the legislature during the next regular legislative session.

The clinical committee shall annually review one existing health coverage mandate and report its findings to the legislature, including recommendations as to whether the mandate should remain a part of mandatory health coverage.

## PART VIII.
## MISCELLANEOUS PROVISIONS

NEW SECTION. **Sec. 801.** Part headings and captions used in this act are not any part of the law.

NEW SECTION. **Sec. 802.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

**--- END ---**