
SENATE BILL 6178

State of Washington

62nd Legislature

2012 Regular Session

By Senators Keiser, Conway, Shin, Frockt, Kline, Pflug, and Chase; by request of Governor Gregoire and Insurance Commissioner

Read first time 01/13/12. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to furthering state implementation of the health
2 benefit exchange and related provisions of the affordable care act;
3 amending RCW 48.42.010, 48.42.020, 43.71.030, 43.71.060, 48.41.060,
4 48.41.110, and 48.41.170; reenacting and amending RCW 48.43.005; adding
5 new sections to chapter 48.43 RCW; adding a new section to chapter
6 43.71 RCW; adding new sections to chapter 48.41 RCW; repealing RCW
7 48.43.018, 48.41.020, 48.41.100, and 48.41.200; prescribing penalties;
8 providing an effective date; and declaring an emergency.

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

10 **Sec. 1.** RCW 48.42.010 and 1985 c 264 s 15 are each amended to read
11 as follows:

12 (1) Notwithstanding any other provision of law, and except as
13 provided in this chapter, any person or other entity which provides
14 coverage in this state for life insurance, annuities, loss of time,
15 medical, surgical, chiropractic, physical therapy, speech pathology,
16 audiology, professional mental health, dental, hospital, or optometric
17 expenses, whether the coverage is by direct payment, reimbursement, the
18 providing of services, or otherwise, shall be subject to the authority
19 of the state insurance commissioner, unless the person or other entity

1 shows that while providing the services it is subject to the
2 jurisdiction and regulation of another agency of this state, any
3 subdivisions thereof, or the federal government.

4 (2) "Another agency of this state, any subdivision thereof, or the
5 federal government" does not include the Washington health benefit
6 exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

7 **Sec. 2.** RCW 48.42.020 and 1983 c 36 s 2 are each amended to read
8 as follows:

9 (1) A person or entity may show that it is subject to the
10 jurisdiction and regulation of another agency of this state, any
11 subdivision thereof, or the federal government, by providing to the
12 insurance commissioner the appropriate certificate, license, or other
13 document issued by the other governmental agency which permits or
14 qualifies it to provide the coverage as defined in RCW 48.42.010.

15 (2) "Another agency of this state, any subdivision thereof, or the
16 federal government" does not include the Washington health benefit
17 exchange under chapter 43.71 RCW or P.L. 111-148 of 2010, as amended.

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

20 Certification by the Washington health benefit exchange of a plan
21 as a qualified health plan, or of a carrier as a qualified issuer, does
22 not exempt the plan or carrier from any of the requirements of this
23 title or rules adopted by the commissioner pursuant to chapter 34.05
24 RCW.

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

27 (1) A carrier may not offer any individual health benefit plan
28 outside the Washington health benefit exchange unless the carrier also
29 offers a silver level and gold level individual qualified health plan
30 through the exchange; and

31 (2) A carrier may not offer any small group health benefit plan
32 outside the Washington health benefit exchange unless the carrier also
33 offers a silver level and gold level small group qualified health plan
34 through the exchange.

1 (3) Except for grandfathered catastrophic health benefit plans that
2 are renewed, a carrier may not offer a catastrophic health benefit plan
3 outside the Washington health benefit exchange unless the carrier
4 offers the same health benefit plan through the exchange.

5 (4) A carrier may not offer outside the Washington health benefit
6 exchange a plan that meets the criteria for a catastrophic health plan
7 under section 1302(4)(A)(e) of P.L. 111-148 of 2010, as amended, with
8 a benefit design that includes covering three primary care visits
9 regardless of whether the deductible has been satisfied.

10 (5) A carrier may not offer outside the Washington health benefit
11 exchange a health benefit plan that meets the definition of a bronze
12 level qualified health plan under section 1302 of P.L. 111-148 of 2010,
13 as amended, unless the carrier offers the same plan through the
14 exchange.

15 (6) For purposes of this section, "Washington health benefit
16 exchange" or "exchange" means the exchange as defined in chapter 43.71
17 RCW. The terms "bronze level," "silver level," and "gold level" mean
18 a health benefit plan as defined as "bronze level," "silver level," or
19 "gold level" under section 1302(d) of P.L. 111-148 of 2010, as amended,
20 and any standards adopted by or for the Washington health benefit
21 exchange.

22 (7) The commissioner may enforce this section by any of the
23 following actions or combination thereof:

24 (a) Issuance of a cease and desist order to any carrier violating
25 these requirements;

26 (b) Imposition of a penalty of twenty-five thousand dollars on the
27 carrier for each violation of this section; or

28 (c) Suspension or revocation of the carrier's certificate of
29 authority or certification of registration.

30 NEW SECTION. **Sec. 5.** A new section is added to chapter 43.71 RCW
31 to read as follows:

32 (1) The board shall certify a plan as a qualified health plan to be
33 offered through the exchange if the plan:

34 (a) Is determined by the insurance commissioner to meet the
35 requirements of Title 48 RCW and rules adopted by the commissioner
36 pursuant to chapter 34.05 RCW;

1 (b) Is determined by the board to meet the requirements of the
2 federal affordable care act for certification as a qualified health
3 plan; and

4 (c) Is determined by the board to meet any additional requirements
5 that the insurance commissioner agrees to adopt in rule at the request
6 of the board. Any additional requirements should prioritize the
7 interests of individuals and small businesses served by the exchange,
8 and be intended to encourage: (i) Carriers to offer health plans in
9 the exchange; (ii) enrollment in plans in the exchange of a diverse
10 population with a range of health care needs; (iii) competition among
11 carriers based on quality, price, and service; and (iv) a variety of
12 plan choices among benefit tier levels.

13 (2) Upon request by the board, a state agency shall provide
14 information to the board for its use in determining if the requirements
15 under subsection (1)(b) or (c) of this section have been met. Unless
16 the agency and the board agree to a later date, the agency shall
17 provide the information within sixty days of the request. The exchange
18 shall reimburse the agency for the cost of compiling and providing the
19 requested information within one hundred eighty days of its receipt.

20 (3) A decision by the board denying a request to certify a plan as
21 a qualified health plan may be appealed according to procedures adopted
22 by the board.

23 NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW
24 to read as follows:

25 The commissioner may adopt in rule additional requirements for a
26 plan to be certified as a qualified health plan only as requested by
27 the board of the health benefit exchange under section 5(1)(c) of this
28 act.

29 **Sec. 7.** RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are
30 each reenacted and amended to read as follows:

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

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

1 (2) "Adverse benefit determination" means a denial, reduction, or
2 termination of, or a failure to provide or make payment, in whole or in
3 part, for a benefit, including a denial, reduction, termination, or
4 failure to provide or make payment that is based on a determination of
5 an enrollee's or applicant's eligibility to participate in a plan, and
6 including, with respect to group health plans, a denial, reduction, or
7 termination of, or a failure to provide or make payment, in whole or in
8 part, for a benefit resulting from the application of any utilization
9 review, as well as a failure to cover an item or service for which
10 benefits are otherwise provided because it is determined to be
11 experimental or investigational or not medically necessary or
12 appropriate.

13 (3) "Applicant" means a person who applies for enrollment in an
14 individual health plan as the subscriber or an enrollee, or the
15 dependent or spouse of a subscriber or enrollee.

16 (4) "Basic health plan" means the plan described under chapter
17 70.47 RCW, as revised from time to time.

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

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

24 (7)(a) For grandfathered health benefit plans issued before January
25 1, 2014, and renewed thereafter, "catastrophic health plan" means:

26 ((+a)) (i) In the case of a contract, agreement, or policy
27 covering a single enrollee, a health benefit plan requiring a calendar
28 year deductible of, at a minimum, one thousand seven hundred fifty
29 dollars and an annual out-of-pocket expense required to be paid under
30 the plan (other than for premiums) for covered benefits of at least
31 three thousand five hundred dollars, both amounts to be adjusted
32 annually by the insurance commissioner; and

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

1 thousand dollars, both amounts to be adjusted annually by the insurance
2 commissioner(~~;~~ ~~or~~

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

8 (b) In July 2008, and in each July thereafter, the insurance
9 commissioner shall adjust the minimum deductible and out-of-pocket
10 expense required for a plan to qualify as a catastrophic plan to
11 reflect the percentage change in the consumer price index for medical
12 care for a preceding twelve months, as determined by the United States
13 department of labor. The adjusted amount shall apply on the following
14 January 1st.

15 (c) For health benefit plans issued on or after January 1, 2014,
16 "catastrophic health plan" means:

17 (i) A health benefit plan that meets the definition of catastrophic
18 plan set forth in section 1302(e) of P.L. 111-148 of 2010, as amended;
19 or

20 (ii) A health benefit plan offered outside the exchange marketplace
21 that requires a calendar year deductible or out-of-pocket expenses
22 under the plan, other than for premiums, for covered benefits, that
23 meets or exceeds the commissioner's annual adjustment under (b) of this
24 subsection.

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

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

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

37 (11) "Dependent" means, at a minimum, the enrollee's legal spouse

1 and dependent children who qualify for coverage under the enrollee's
2 health benefit plan.

3 (12) "Emergency medical condition" means a medical condition
4 manifesting itself by acute symptoms of sufficient severity, including
5 severe pain, such that a prudent layperson, who possesses an average
6 knowledge of health and medicine, could reasonably expect the absence
7 of immediate medical attention to result in a condition (a) placing the
8 health of the individual, or with respect to a pregnant woman, the
9 health of the woman or her unborn child, in serious jeopardy, (b)
10 serious impairment to bodily functions, or (c) serious dysfunction of
11 any bodily organ or part.

12 (13) "Emergency services" means a medical screening examination, as
13 required under section 1867 of the social security act (42 U.S.C.
14 1395dd), that is within the capability of the emergency department of
15 a hospital, including ancillary services routinely available to the
16 emergency department to evaluate that emergency medical condition, and
17 further medical examination and treatment, to the extent they are
18 within the capabilities of the staff and facilities available at the
19 hospital, as are required under section 1867 of the social security act
20 (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect
21 to an emergency medical condition, has the meaning given in section
22 1867(e)(3) of the social security act (42 U.S.C. 1395dd(e)(3)).

23 (14) "Employee" has the same meaning given to the term, as of
24 January 1, 2008, under section 3(6) of the federal employee retirement
25 income security act of 1974.

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

30 (16) "Final external review decision" means a determination by an
31 independent review organization at the conclusion of an external
32 review.

33 (17) "Final internal adverse benefit determination" means an
34 adverse benefit determination that has been upheld by a health plan or
35 carrier at the completion of the internal appeals process, or an
36 adverse benefit determination with respect to which the internal
37 appeals process has been exhausted under the exhaustion rules described
38 in RCW 48.43.530 and 48.43.535.

1 (18) "Grandfathered health plan" means a group health plan or an
2 individual health plan that under section 1251 of the patient
3 protection and affordable care act, P.L. 111-148 (2010) and as amended
4 by the health care and education reconciliation act, P.L. 111-152
5 (2010) is not subject to subtitles A or C of the act as amended.

6 (19) "Grievance" means a written complaint submitted by or on
7 behalf of a covered person regarding: (a) Denial of payment for
8 medical services or nonprovision of medical services included in the
9 covered person's health benefit plan, or (b) service delivery issues
10 other than denial of payment for medical services or nonprovision of
11 medical services, including dissatisfaction with medical care, waiting
12 time for medical services, provider or staff attitude or demeanor, or
13 dissatisfaction with service provided by the health carrier.

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

27 (21) "Health care provider" or "provider" means:

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

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

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

36 (23) "Health carrier" or "carrier" means a disability insurer
37 regulated under chapter 48.20 or 48.21 RCW, a health care service
38 contractor as defined in RCW 48.44.010, or a health maintenance

1 organization as defined in RCW 48.46.020, and includes "issuers" as
2 that term is used in the patient protection and affordable care act
3 (P.L. 111-148).

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

7 (a) Long-term care insurance governed by chapter 48.84 or 48.83
8 RCW;

9 (b) Medicare supplemental health insurance governed by chapter
10 48.66 RCW;

11 (c) Coverage supplemental to the coverage provided under chapter
12 55, Title 10, United States Code;

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

15 (e) Disability income;

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

19 (g) Workers' compensation coverage;

20 (h) Accident only coverage;

21 (i) Specified disease or illness-triggered fixed payment insurance,
22 hospital confinement fixed payment insurance, or other fixed payment
23 insurance offered as an independent, noncoordinated benefit;

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

25 (k) Dental only and vision only coverage; and

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

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

36 (26) "Open enrollment" means a period of time as defined in rule to
37 be held at the same time each year, during which applicants may enroll

1 in a carrier's individual health benefit plan without being subject to
2 health screening or otherwise required to provide evidence of
3 insurability as a condition for enrollment.

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

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

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

19 (30) "Small employer" or "small group" means any person, firm,
20 corporation, partnership, association, political subdivision, sole
21 proprietor, or self-employed individual that is actively engaged in
22 business that employed an average of at least one but no more than
23 fifty employees, during the previous calendar year and employed at
24 least one employee on the first day of the plan year, is not formed
25 primarily for purposes of buying health insurance, and in which a bona
26 fide employer-employee relationship exists. In determining the number
27 of employees, companies that are affiliated companies, or that are
28 eligible to file a combined tax return for purposes of taxation by this
29 state, shall be considered an employer. Subsequent to the issuance of
30 a health plan to a small employer and for the purpose of determining
31 eligibility, the size of a small employer shall be determined annually.
32 Except as otherwise specifically provided, a small employer shall
33 continue to be considered a small employer until the plan anniversary
34 following the date the small employer no longer meets the requirements
35 of this definition. A self-employed individual or sole proprietor who
36 is covered as a group of one must also: (a) Have been employed by the
37 same small employer or small group for at least twelve months prior to
38 application for small group coverage, and (b) verify that he or she

1 derived at least seventy-five percent of his or her income from a trade
2 or business through which the individual or sole proprietor has
3 attempted to earn taxable income and for which he or she has filed the
4 appropriate internal revenue service form 1040, schedule C or F, for
5 the previous taxable year, except a self-employed individual or sole
6 proprietor in an agricultural trade or business, must have derived at
7 least fifty-one percent of his or her income from the trade or business
8 through which the individual or sole proprietor has attempted to earn
9 taxable income and for which he or she has filed the appropriate
10 internal revenue service form 1040, for the previous taxable year.

11 (31) "Special enrollment" means a defined period of time of not
12 less than thirty-one days, triggered by a specific qualifying event
13 experienced by the applicant, during which applicants may enroll in the
14 carrier's individual health benefit plan without being subject to
15 health screening or otherwise required to provide evidence of
16 insurability as a condition for enrollment.

17 (32) "Standard health questionnaire" means the standard health
18 questionnaire designated under chapter 48.41 RCW.

19 (33) "Utilization review" means the prospective, concurrent, or
20 retrospective assessment of the necessity and appropriateness of the
21 allocation of health care resources and services of a provider or
22 facility, given or proposed to be given to an enrollee or group of
23 enrollees.

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

31 **Sec. 8.** RCW 43.71.030 and 2011 c 317 s 4 are each amended to read
32 as follows:

- 33 (1) The exchange may, consistent with the purposes of this chapter:
34 (a) Sue and be sued in its own name; (b) make and execute agreements,
35 contracts, and other instruments, with any public or private person or
36 entity; (c) employ, contract with, or engage personnel; (d) pay
37 administrative costs; and (e) accept grants, donations, loans of funds,

1 and contributions in money, services, materials or otherwise, from the
2 United States or any of its agencies, from the state of Washington and
3 its agencies or from any other source, and use or expend those moneys,
4 services, materials, or other contributions.

5 (2) (~~The powers and duties of the exchange and the board are~~
6 ~~limited to those necessary to apply for and administer grants,~~
7 ~~establish information technology infrastructure, and undertake~~
8 ~~additional administrative functions necessary to begin operation of the~~
9 ~~exchange by January 1, 2014. Any actions relating to substantive~~
10 ~~issues included in RCW 43.71.040 must be consistent with statutory~~
11 ~~direction on those issues.)) The exchange shall report its activities
12 and status to the governor and the legislature as requested, and no
13 less often than annually.~~

14 **Sec. 9.** RCW 43.71.060 and 2011 c 317 s 7 are each amended to read
15 as follows:

16 The health benefit exchange account is created in the custody of
17 the state treasurer. All receipts from federal grants received under
18 the affordable care act shall be deposited into the account.
19 Expenditures from the account may be used only for purposes consistent
20 with the grants. Until March 15, 2012, only the administrator of the
21 health care authority, or his or her designee, may authorize
22 expenditures from the account. Beginning March 15, 2012, only the
23 board of the Washington health benefit exchange, or its designee, may
24 authorize expenditures from the account. The account is subject to
25 allotment procedures under chapter 43.88 RCW, but an appropriation is
26 not required for expenditures.

27 **Sec. 10.** RCW 48.41.060 and 2011 c 314 s 13 are each amended to
28 read as follows:

29 (1) The board shall have the general powers and authority granted
30 under the laws of this state to insurance companies, health care
31 service contractors, and health maintenance organizations, licensed or
32 registered to offer or provide the kinds of health coverage defined
33 under this title. In addition thereto, the board shall:

34 (a) (~~Designate or establish the standard health questionnaire to~~
35 ~~be used under RCW 48.41.100 and 48.43.018, including the form and~~
36 ~~content of the standard health questionnaire and the method of its~~

1 application. The questionnaire must provide for an objective
2 evaluation of an individual's health status by assigning a discreet
3 measure, such as a system of point scoring to each individual. The
4 questionnaire must not contain any questions related to pregnancy, and
5 pregnancy shall not be a basis for coverage by the pool. The
6 questionnaire shall be designed such that it is reasonably expected to
7 identify the eight percent of persons who are the most costly to treat
8 who are under individual coverage in health benefit plans, as defined
9 in RCW 48.43.005, in Washington state or are covered by the pool, if
10 applied to all such persons;

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

14 (c) Approve the standard health questionnaire and any modifications
15 needed to comply with this chapter. The standard health questionnaire
16 shall be submitted to an actuary for certification, modified as
17 necessary, and approved at least every thirty six months unless at the
18 time when certification is required the pool will be discontinued
19 before the end of the succeeding thirty six month period. The
20 designation and approval of the standard health questionnaire by the
21 board shall not be subject to review and approval by the commissioner.
22 The standard health questionnaire or any modification thereto shall not
23 be used until ninety days after public notice of the approval of the
24 questionnaire or any modification thereto, except that the initial
25 standard health questionnaire approved for use by the board after March
26 23, 2000, may be used immediately following public notice of such
27 approval;

28 (d)) Establish appropriate rates, rate schedules, rate
29 adjustments, expense allowances, claim reserve formulas and any other
30 actuarial functions appropriate to the operation of the pool. Rates
31 shall not be unreasonable in relation to the coverage provided, the
32 risk experience, and expenses of providing the coverage. Rates and
33 rate schedules may be adjusted for appropriate risk factors such as age
34 and area variation in claim costs and shall take into consideration
35 appropriate risk factors in accordance with established actuarial
36 underwriting practices consistent with Washington state individual plan
37 rating requirements under RCW 48.44.022 and 48.46.064;

1 ~~((e))~~ (b)(i) Assess members of the pool in accordance with the
2 provisions of this chapter, and make advance interim assessments as may
3 be reasonable and necessary for the organizational or interim operating
4 expenses. Any interim assessments will be credited as offsets against
5 any regular assessments due following the close of the year.

6 (ii) Self-funded multiple employer welfare arrangements are subject
7 to assessment under this subsection only in the event that assessments
8 are not preempted by the employee retirement income security act of
9 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the
10 commissioner shall initially request an advisory opinion from the
11 United States department of labor or obtain a declaratory ruling from
12 a federal court on the legality of imposing assessments on these
13 arrangements before imposing the assessment. Once the legality of the
14 assessments has been determined, the multiple employer welfare
15 arrangement certified by the insurance commissioner must begin payment
16 of these assessments.

17 (iii) If there has not been a final determination of the legality
18 of these assessments, then beginning on the earlier of (A) the date the
19 fourth multiple employer welfare arrangement has been certified by the
20 insurance commissioner, or (B) April 1, 2006, the arrangement shall
21 deposit the assessments imposed by this subsection into an interest
22 bearing escrow account maintained by the arrangement. Upon a final
23 determination that the assessments are not preempted by the employee
24 retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001
25 et seq., all funds in the interest bearing escrow account shall be
26 transferred to the board;

27 ~~((f))~~ (c) Issue policies of health coverage in accordance with
28 the requirements of this chapter; and

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

31 ~~(h) Contract with the Washington state health care authority for
32 the administration of the premium discounts provided under RCW
33 48.41.200(3)(a) (i) and (ii);~~

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

37 ~~(j))~~ (d) Provide certification to the commissioner when

1 assessments will exceed the threshold level established in RCW
2 48.41.037.

3 (2) In addition thereto, the board may:

4 (a) Enter into contracts as are necessary or proper to carry out
5 the provisions and purposes of this chapter including the authority,
6 with the approval of the commissioner, to enter into contracts with
7 similar pools of other states for the joint performance of common
8 administrative functions, or with persons or other organizations for
9 the performance of administrative functions;

10 (b) Sue or be sued, including taking any legal action as necessary
11 to avoid the payment of improper claims against the pool or the
12 coverage provided by or through the pool;

13 (c) Appoint appropriate legal, actuarial, and other committees as
14 necessary to provide technical assistance in the operation of the pool,
15 policy, and other contract design, and any other function within the
16 authority of the pool; and

17 (d) Conduct periodic audits to assure the general accuracy of the
18 financial data submitted to the pool, and the board shall cause the
19 pool to have an annual audit of its operations by an independent
20 certified public accountant.

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

23 **Sec. 11.** RCW 48.41.110 and 2011 c 315 s 6 are each amended to read
24 as follows:

25 (1) The pool shall offer one or more care management plans of
26 coverage. Such plans may, but are not required to, include point of
27 service features that permit participants to receive in-network
28 benefits or out-of-network benefits subject to differential cost
29 shares. The pool may incorporate managed care features into existing
30 plans.

31 (2) The administrator shall prepare a brochure outlining the
32 benefits and exclusions of pool policies in plain language. After
33 approval by the board, such brochure shall be made reasonably available
34 to participants or potential participants.

35 (3) The health insurance policies issued by the pool shall pay only
36 reasonable amounts for medically necessary eligible health care
37 services rendered or furnished for the diagnosis or treatment of

1 covered illnesses, injuries, and conditions. Eligible expenses are the
2 reasonable amounts for the health care services and items for which
3 benefits are extended under a pool policy.

4 (4) The pool shall offer at least two policies, one of which will
5 be a comprehensive policy that must comply with RCW 48.41.120 and must
6 at a minimum include the following services or related items:

7 (a) Hospital services, including charges for the most common
8 semiprivate room, for the most common private room if semiprivate rooms
9 do not exist in the health care facility, or for the private room if
10 medically necessary, including no less than a total of one hundred
11 eighty inpatient days in a calendar year, and no less than thirty days
12 inpatient care for alcohol, drug, or chemical dependency or abuse per
13 calendar year;

14 (b) Professional services including surgery for the treatment of
15 injuries, illnesses, or conditions, other than dental, which are
16 rendered by a health care provider, or at the direction of a health
17 care provider, by a staff of registered or licensed practical nurses,
18 or other health care providers;

19 (c) No less than twenty outpatient professional visits for the
20 diagnosis or treatment of alcohol, drug, or chemical dependency or
21 abuse rendered during a calendar year by a state-certified chemical
22 dependency program approved under chapter 70.96A RCW, or by one or more
23 physicians, psychologists, or community mental health professionals,
24 or, at the direction of a physician, by other qualified licensed health
25 care practitioners;

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

27 (e) Services of a skilled nursing facility, excluding custodial and
28 convalescent care, for not less than one hundred days in a calendar
29 year as prescribed by a physician;

30 (f) Services of a home health agency;

31 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
32 therapy;

33 (h) Oxygen;

34 (i) Anesthesia services;

35 (j) Prostheses, other than dental;

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

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

1 (m) Oral surgery including at least the following: Fractures of
2 facial bones; excisions of mandibular joints, lesions of the mouth,
3 lip, or tongue, tumors, or cysts excluding treatment for
4 temporomandibular joints; incision of accessory sinuses, mouth salivary
5 glands or ducts; dislocations of the jaw; plastic reconstruction or
6 repair of traumatic injuries occurring while covered under the pool;
7 and excision of impacted wisdom teeth;

8 (n) Maternity care services;

9 (o) Services of a physical therapist and services of a speech
10 therapist;

11 (p) Hospice services;

12 (q) Professional ambulance service to the nearest health care
13 facility qualified to treat the illness or injury;

14 (r) Mental health services pursuant to RCW 48.41.220; and

15 (s) Other medical equipment, services, or supplies required by
16 physician's orders and medically necessary and consistent with the
17 diagnosis, treatment, and condition.

18 (5) The board shall design and employ cost containment measures and
19 requirements such as, but not limited to, care coordination, provider
20 network limitations, preadmission certification, and concurrent
21 inpatient review which may make the pool more cost-effective.

22 (6) The pool benefit policy may contain benefit limitations,
23 exceptions, and cost shares such as copayments, coinsurance, and
24 deductibles that are consistent with managed care products, except that
25 differential cost shares may be adopted by the board for nonnetwork
26 providers under point of service plans. No limitation, exception, or
27 reduction may be used that would exclude coverage for any disease,
28 illness, or injury.

29 (7)(a) The pool may not reject an individual for health plan
30 coverage based upon preexisting conditions of the individual or deny,
31 exclude, or otherwise limit coverage for an individual's preexisting
32 health conditions; except that it shall impose a six-month benefit
33 waiting period for preexisting conditions for which medical advice was
34 given, for which a health care provider recommended or provided
35 treatment, or for which a prudent layperson would have sought advice or
36 treatment, within six months before the effective date of coverage.
37 The preexisting condition waiting period shall not apply to prenatal
38 care services or extend beyond December 31, 2013. The pool may not

1 avoid the requirements of this section through the creation of a new
2 rate classification or the modification of an existing rate
3 classification. Credit against the waiting period shall be as provided
4 in subsection (8) of this section.

5 (b) The pool shall not impose any preexisting condition waiting
6 period for any person under the age of nineteen.

7 (8)(a) Except as provided in (b) of this subsection, the pool shall
8 credit any preexisting condition waiting period in its plans for a
9 person who was enrolled at any time during the sixty-three day period
10 immediately preceding the date of application for the new pool plan.
11 For the person previously enrolled in a group health benefit plan, the
12 pool must credit the aggregate of all periods of preceding coverage not
13 separated by more than sixty-three days toward the waiting period of
14 the new health plan. For the person previously enrolled in an
15 individual health benefit plan other than a catastrophic health plan,
16 the pool must credit the period of coverage the person was continuously
17 covered under the immediately preceding health plan toward the waiting
18 period of the new health plan. For the purposes of this subsection, a
19 preceding health plan includes an employer-provided self-funded health
20 plan.

21 (b) The pool shall waive any preexisting condition waiting period
22 for a person who is an eligible individual as defined in section
23 2741(b) of the federal health insurance portability and accountability
24 act of 1996 (42 U.S.C. 300gg-41(b)).

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

29 (10) The pool shall contract with organizations that provide care
30 management that has been demonstrated to be effective and shall
31 encourage enrollees who are eligible for care management services to
32 participate. The pool may encourage the use of shared decision making
33 and certified decision aids for preference-sensitive care areas.

34 **Sec. 12.** RCW 48.41.170 and 1987 c 431 s 17 are each amended to
35 read as follows:

36 The commissioner shall adopt rules pursuant to chapter 34.05 RCW
37 that(+

1 ~~(1) Provide for disclosure by the member of the availability of~~
2 ~~insurance coverage from the pool; and~~
3 ~~(2))~~ implement this chapter.

4 NEW SECTION. **Sec. 13.** A new section is added to chapter 48.41 RCW
5 to read as follows:

6 For policies renewed beginning January 1, 2014, rates for pool
7 coverage may be no more than the average individual standard rate
8 charged for coverage comparable to pool coverage by the five largest
9 members, measured in terms of individual market enrollment, offering
10 such coverages in the state. In the event five members do not offer
11 comparable coverage, rates for pool coverage may be no more than the
12 standard risk rate established using reasonable actuarial techniques
13 and must reflect anticipated experience and expenses for such coverage
14 in the individual market.

15 NEW SECTION. **Sec. 14.** A new section is added to chapter 48.41 RCW
16 to read as follows:

17 Only persons enrolled in a health benefit plan through the pool on
18 December 31, 2013, who do not disenroll after December 31, 2013, are
19 eligible for pool coverage.

20 NEW SECTION. **Sec. 15.** The following acts or parts of acts, as now
21 existing or hereafter amended, are each repealed, effective January 1,
22 2014:

- 23 (1) RCW 48.43.018 (Requirement to complete the standard health
24 questionnaire--Exemptions--Results) and 2010 c 277 s 1 & 2009 c 42 s 1;
- 25 (2) RCW 48.41.020 (Intent) and 2000 c 79 s 5 & 1987 c 431 s 2;
- 26 (3) RCW 48.41.100 (Eligibility for coverage) and 2011 c 315 s 5,
27 2011 c 314 s 15, 2009 c 555 s 3, 2007 c 259 s 30, 2001 c 196 s 3, 2000
28 c 79 s 12, 1995 c 34 s 5, 1989 c 121 s 7, & 1987 c 431 s 10; and
- 29 (4) RCW 48.41.200 (Rates--Standard risk and maximum) and 2007 c 259
30 s 28, 2000 c 79 s 17, 1997 c 231 s 214, & 1987 c 431 s 20.

31 NEW SECTION. **Sec. 16.** If any provision or clause of this act or
32 application thereof to any person or circumstance is held invalid, such
33 invalidity shall not affect other provisions or applications of the act

1 which can be given effect without the invalid provision or application,
2 and to this end the provisions of this act are declared to be
3 severable.

4 NEW SECTION. **Sec. 17.** Sections 10, 12, and 14 of this act take
5 effect January 1, 2014.

6 NEW SECTION. **Sec. 18.** Sections 8 and 9 of this act are necessary
7 for the immediate preservation of the public peace, health, or safety,
8 or support of the state government and its existing public
9 institutions, and take effect immediately.

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