SHB 2355 - H AMD **689**
By Representative Cody

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** DEFINITIONS. The definitions in this
4 section apply throughout this chapter unless the context clearly
5 requires otherwise.
6 (1) "Association" means the Washington vaccine association
7 established in chapter 70.290 RCW.
8 (2) "Attachment point" means the threshold amount for claims
9 costs incurred by an eligible health carrier for an enrolled
10 individual's covered benefits in a benefit year, above which the
11 claims costs for benefits are eligible for reinsurance payments under
12 the Washington reinsurance program.
13 (3) "Benefit year" means the calendar year during which an
14 eligible health carrier provides coverage through an individual
15 health plan.
16 (4) "Board" means the Washington reinsurance program management
17 board.
18 (5) "Coinsurance rate" means the percentage rate at which the
19 Washington reinsurance program will reimburse an eligible health
20 carrier for claims incurred for an enrolled individual's covered
21 benefits in a benefit year above the attachment point and below the
22 reinsurance cap.
23 (6) "Commissioner" means the insurance commissioner.
24 (7) "Covered lives" means all persons residing in Washington
25 state who are:
26 (a) Covered under an individual or group health plan issued or
27 delivered in Washington state or an individual or group health plan
28 that otherwise provides benefits to Washington residents; or
29 (b) Enrolled in a group health plan administered by a third-party
30 administrator.

(8) "Eligible health carrier" means a health carrier offering nongrandfathered individual health plans to consumers in Washington state.

(9) "Health carrier" or "carrier" has the same meaning as in RCW 48.43.005.

(10) "Health plan" means any arrangement by which persons, including dependents or spouses, have access to hospital and medical benefits or reimbursement including any group or individual disability insurance policy; health care service contract; health maintenance agreement; uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not involving insurance or not governed by Title 48 RCW; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by governmental benefits. "Health plan" does not include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, a direct practice as defined in RCW 48.150.010, coverage provided pursuant to Title XIX of the social security act, 42 U.S.C. Sec. 1396 et seq., or coverage where the federal government is the primary payor, including, but not limited to, coverage provided under the federal employees health benefit program, the tricare program, or the medicare program.

(11) "Individual health plan" means a health plan as defined in RCW 48.43.005 that is offered by a health carrier to individuals other than in connection with a group health plan, and that is not a grandfathered health plan as defined in RCW 48.43.005.

(12) "Individual market" has the same meaning as in RCW 48.43.005.

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

(14) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the Washington reinsurance program.

1 (15) "Reinsurance cap" means the threshold amount for claims
2 costs incurred by an eligible health carrier for an enrolled
3 individual's covered benefits, over which the claims costs for
4 benefits are no longer eligible for reinsurance payments.
5 (16) "Reinsurance payments" means an amount paid by the
6 Washington reinsurance program to an eligible health carrier under
7 the program.
8 (17) "Reinsurance plan of operation" means the plan of operation
9 proposed by the board and approved by the commissioner under section
10 4 of this act.
11 (18) "Third-party administrator" means any person or entity who,
12 on behalf of a health carrier or health care purchaser, receives or
13 collects charges, contributions, or premiums for, or adjusts or
14 settles claims on or for, residents of Washington state or Washington
15 health care providers and facilities.
16 (19) "Washington reinsurance program," "reinsurance program," or
17 "program" means the state-based reinsurance program established under
18 this chapter.

19 NEW SECTION. **Sec. 2.** WASHINGTON REINSURANCE PROGRAM—CREATION,
20 ADMINISTRATION, BOARD DUTIES. (1) The Washington reinsurance program
21 is established for the purposes of stabilizing the rates and premiums
22 for individual health plans and providing greater financial certainty
23 to consumers of health insurance in this state.
24 (2) The program must be operated by the association through the
25 board in accordance with the reinsurance plan of operation approved
26 by the commissioner under section 4 of this act. The association must
27 appoint the Washington reinsurance program management board
28 consisting of the following members:
29 (a) The insurance commissioner or his or her designee, who serves
30 as a nonvoting member;
31 (b) A member representing the Washington health benefit exchange,
32 who serves as a nonvoting member;
33 (c) A member representing small employers with fifty or fewer
34 employees;
35 (d) A member representing self-insured large employers with more
36 than fifty employees;
37 (e) A member representing fully insured large employers with more
38 than fifty employees;
39 (f) A member representing third-party administrators;

1 (g) A member representing health carriers offering individual
2 market coverage in Washington;
3 (h) A member representing Taft Hartley trust funds;
4 (i) A member with technical expertise in reinsurance;
5 (j) A member of the association's board of directors; and
6 (k) A public member representing consumers who purchase
7 individual market health insurance in Washington.
8 (3) The board has the following powers and duties related to
9 operation of the Washington reinsurance program:
10 (a) Prepare and propose to the association amendments to the
11 articles of organization and bylaws of the association to provide for
12 operation of the Washington reinsurance program;
13 (b) Prepare and adopt a reinsurance plan of operation as provided
14 in section 4 of this act and submit it to the commissioner for
15 approval;
16 (c) Conduct all activities in accordance with the reinsurance
17 plan of operation approved by the commissioner under section 4 of
18 this act;
19 (d) Enter into contracts as necessary to collect and disburse the
20 assessment for reinsurance payments;
21 (e) Enter into contracts as necessary to operate and administer
22 the Washington reinsurance program;
23 (f) Sue or be sued, including taking any legal action necessary
24 or proper for the recovery of any assessment for, on behalf of, or
25 against health carriers and third-party administrators or other
26 participating persons for reinsurance payments;
27 (g) Appoint, from among members of the board, committees as
28 necessary to provide technical assistance in the operation of the
29 program;
30 (h) Hire independent consultants, including accountants,
31 actuaries, attorneys, investment advisors, and auditors, as the board
32 deems necessary for operation of the Washington reinsurance program;
33 (i) Conduct periodic audits to assure the general accuracy of the
34 financial data submitted to the program. In designing the audit
35 procedures, the board shall take into consideration the auditing
36 conducted by the federal department of health and human services'
37 risk adjustment program under 42 U.S.C. Sec. 18063;
38 (j) Cause the reinsurance program to be audited by an independent
39 certified public accountant;

1 (k) Borrow and repay such working capital, reserve, or other
2 funds as, in the judgment of the board, may be necessary for the
3 operation of the program;
4 (l) Contract with an entity for program administration. The board
5 may contract with any entity that is under contract with the
6 association on the effective date of this section as needed for
7 operation of the Washington reinsurance program for the period of the
8 current contract. Prior to the appointment of the board, the
9 association may enter into a contract with the entity administering
10 the vaccine association program or its affiliate for reinsurance
11 program planning and development. Any subsequent contract for
12 administration of the association's other duties must include duties
13 as may be assigned by the board that are necessary for operation of
14 the Washington reinsurance program for the period during which the
15 program will be in effect; and
16 (m) Perform any other functions to carry out the reinsurance plan
17 of operation and to effect any or all of the purposes for which the
18 program is organized.
19 (4) This section does not require or authorize the adoption of
20 rules by the board under chapter 34.05 RCW.

21 NEW SECTION. **Sec. 3.** EXAMINATION, REPORT, AND ENFORCEMENT. (1)
22 The Washington reinsurance program is subject to examination by the
23 commissioner as provided under chapter 48.03 RCW.
24 (2) The board shall submit to the commissioner, by November 1st
25 of the year following the applicable benefit year or sixty calendar
26 days following the final disbursement of reinsurance payments for the
27 applicable benefit year, whichever is later, a financial report for
28 the applicable benefit year in a form approved by the commissioner.
29 The report must include the following information for the benefit
30 year that is the subject of the report, at a minimum:
31 (a) Funds received by the program, excluding funds collected on
32 behalf of the Washington state health insurance pool under section 15
33 of this act;
34 (b) A list of health carriers and third-party administrators that
35 failed to remit assessments under section 6 of this act;
36 (c) Requests for reinsurance payments received from eligible
37 health carriers;
38 (d) Reinsurance payments made to eligible health carriers; and

(e) Administrative and operational expenses incurred for the program.

(3) The report must be posted on the association's web site or a Washington reinsurance program web site established by the board.

NEW SECTION. **Sec. 4.** REINSURANCE PROGRAM PLAN OF OPERATION. The reinsurance plan of operation for the Washington reinsurance program must be submitted by the board to the commissioner for review by May 15, 2018, and must be approved by the commissioner by June 1, 2018. The plan of operation must:

(1) Provide for the operation of the Washington reinsurance program separate and apart from the association's other duties, including the segregation of funds used for the program;

(2) Establish procedures for the handling and accounting of assets and moneys of the program;

(3) Establish regular times and places for meetings of the board in connection with operation of the program;

(4) Establish data and information requirements for submission of reinsurance payment requests by eligible health carriers, processes for notification of eligible health carriers regarding reinsurance payments and issuing payments, and processes to resolve eligible health carrier appeals related to the amount of reinsurance payments, as provided in section 5 of this act;

(5) Establish a schedule and procedures for health carriers and third-party administrators to submit annual statements and other reports deemed necessary by the board to calculate the assessment in section 6 of this act;

(6) Establish procedures for the collection of assessments from health carriers and third-party administrators under section 6 of this act;

(7) Establish procedures to prevent the double-counting of covered lives in the calculation of the assessment in section 6 of this act;

(8) Determine the amount of contingency funding necessary to ensure the continued operation of the program, not to exceed ten percent of gross program assessments;

(9) Establish procedures for records to be kept of all financial transactions and for an annual fiscal reporting to the commissioner as provided in section 3 of this act;

(10) Establish procedures for the submission of data by the program to the commissioner for preparation of quarterly and annual reports required under the terms of a waiver approved under section 8 of this act; and

(11) Contain additional provisions necessary for the execution of the powers and duties of the board.

NEW SECTION. **Sec. 5.** PROGRAM PAYMENTS TO ELIGIBLE HEALTH CARRIERS. (1)(a) The commissioner shall determine the payment parameters for the program annually, in order to:

(i) Manage the program within available assessment resources and federal funding not to exceed the total program funding authorized by the legislature;

(ii) Mitigate the impact of high-cost individuals on premium rates in the individual market;

(iii) Stabilize or reduce premium rates in the individual market; and

(iv) Increase participation in the individual market.

(b) The payment parameters for benefit year 2019 must be consistent with the parameters included in the state innovation waiver approved by the federal government as provided in section 8 of this act. The payment parameters for subsequent years must be established by the commissioner by March 31st of the year before the applicable benefit year. The commissioner must identify any data needed from the program to determine annual payment parameters for each upcoming benefit year, and such data must be timely provided to the commissioner by the program upon the commissioner's request.

(c) The attachment point for the program must be set by the commissioner at an amount between seventy-five thousand dollars and the reinsurance cap. The coinsurance rate shall be set by the commissioner at a percentage rate between fifty and eighty percent. The reinsurance cap shall be set by the commissioner at an amount between five hundred thousand dollars and one million dollars.

(2) An eligible health carrier becomes eligible for a reinsurance payment when:

(a) The claims costs for the covered benefits of an individual enrolled in the eligible health carrier's individual health plan exceed the attachment point;

1 (b) The eligible health carrier has care management strategies
2 available and submits an attestation to the board. The attestation
3 must describe:
4 (i) The care management strategies it will make available; and
5 (ii) The procedures by which enrollees on whose behalf the
6 carrier has submitted claims to the reinsurance program will be
7 offered the opportunity to participate in care management strategies
8 for which the enrollee is eligible; and
9 (c) The eligible health carrier submits its requests for
10 reinsurance payments by April 30th of the year following the
11 applicable benefit year in accordance with any requirements
12 established by the board including, but not limited to, requirements
13 related to the format and structure for submission of claims for
14 reinsurance payments. The claims data needed for submission of claims
15 for reinsurance payments must be drawn from the dedicated data
16 environment established by the eligible health carrier under the
17 federal risk adjustment program under 42 U.S.C. Sec. 18063.
18 (3) The amount of the reinsurance payment is the product of the
19 coinsurance rate and the carrier's claims costs for the individual
20 enrolled in the eligible health carrier's individual health plan that
21 exceed the attachment point, up to the reinsurance cap.
22 (4) For each applicable benefit year, on May 31st of the year
23 following the applicable benefit year, the program must send an
24 initial settlement report to each eligible health carrier in response
25 to their final claims submission for the applicable benefit year. By
26 August 1st of the year following the applicable benefit year, after
27 resolution of any appeals related to the amount of reinsurance
28 payments received, the program must disburse all applicable
29 reinsurance payments to an eligible health carrier.
30 (5)(a) The total annual reinsurance payments made to all eligible
31 health carriers may not exceed two hundred million dollars for any
32 applicable benefit year.
33 (b)(i) If, for any applicable benefit year, the valid claims
34 submitted for reinsurance payments under this section exceed two
35 hundred million dollars, the board must make a pro rata reduction in
36 claims payments necessary to keep reinsurance payments at or below
37 two hundred million dollars;
38 (ii) If, for any applicable benefit year, the funds available to
39 pay valid reinsurance claims are less than two hundred million
40 dollars and are insufficient to fund the valid claims payments under

this section, the board must make a pro rata reduction in claims payments necessary to remain within the funds available for reinsurance payments.

(c) If, for any applicable benefit year, the final disbursement of reinsurance payments to eligible health carriers is less than two hundred million dollars, the remaining funds must be used to reduce assessments for the subsequent applicable calendar year or to establish contingency funds consistent with the plan of operation.

NEW SECTION. **Sec. 6.** PROGRAM ASSESSMENTS. (1) Except as provided in subsection (2) of this section, all health carriers and third-party administrators must pay a quarterly assessment under this section.

(a) On or before October 1, 2018, and on or before May 15th of each subsequent year, the board must determine its proposed per covered life assessment rate for the subsequent calendar year and report the amount to the commissioner for review and approval. The board must determine the proposed covered life assessment rate in the following manner:

(i) The gross assessment amount must be two hundred million dollars plus anticipated administrative expenses not to exceed one and one-half percent of gross program assessments for the subsequent calendar year. The gross assessment amount calculated in 2018 for assessments to be paid in calendar year 2019 may include contingency funds and start-up costs incurred during calendar year 2018 for the development of the program. The gross assessment calculated in subsequent years may not include contingency funds or start-up costs.

(ii) The net assessment amount is the gross assessment minus federal funds received in the prior calendar year under a state innovation waiver approved by the federal government under section 8 of this act, minus any surplus funds to be used to reduce assessments under section 5(5)(c) of this act, minus any other state or federal funds received for the purposes of making reinsurance payments or administering the program.

(iii) The proposed covered life assessment rate is determined by dividing the net assessment amount by the total number of covered lives reported by all health carriers and third-party administrators for the most recent reporting quarter available at the time the assessment is calculated.

1 (b) The commissioner must, by October 15, 2018, and May 25th in
2 subsequent years, approve the assessment rate and notify the board.
3 The board must notify, in writing, each health carrier and third-
4 party administrator of the approved assessment rate by October 20,
5 2018, and June 1st of each subsequent year.

6 (c) Each health carrier's and third-party administrator's
7 quarterly assessment amount is determined based on reports deemed
8 necessary by the board and is determined by multiplying the health
9 carrier's or third-party administrator's total number of covered
10 lives for the most recent reporting quarter by the approved covered
11 life assessment rate.

12 (d) The board must notify, in writing, each health carrier and
13 third-party administrator of its quarterly assessment pursuant to the
14 payment schedule specified in the reinsurance plan of operation.

15 (e) Quarterly payments are due to the board within forty-five
16 days of receipt of the written notification under (d) of this
17 subsection. The board must charge interest, which begins to accrue on
18 the forty-sixth day, on amounts received after the forty-five day
19 period. The board may allow each health carrier and third-party
20 administrator in arrears to submit a payment plan, subject to
21 approval by the board and initial payment under an approved payment
22 plan.

23 (2) A health carrier or third-party administrator is not subject
24 to an assessment under this section if it has fifty or fewer covered
25 lives in Washington.

26 (3) If an assessment against a health carrier or third-party
27 administrator is prohibited by court order, the assessment for the
28 remaining health carriers and third-party administrators may be
29 adjusted in a manner consistent with subsection (1) of this section
30 to ensure that the net assessment amount calculated in subsection
31 (1)(a)(ii) of this section will be collected.

32 (4) In developing the procedures for collection of assessments
33 under this chapter, the board must give strong consideration to the
34 procedures used in the federal transitional reinsurance program
35 established under 42 U.S.C. Sec. 18061.

36 (5) The board may abate or defer, in whole or in part, the
37 assessment of a health carrier or third-party administrator if, in
38 the opinion of the board, payment of the assessment would endanger
39 the ability of the health carrier or third-party administrator to
40 fulfill its contractual obligations. If an assessment against a

1 health carrier or third-party administrator is abated or deferred in
2 whole or in part, the amount by which such assessment is abated or
3 deferred may be assessed against the other health carriers and third-
4 party administrators in a manner consistent with the basis for
5 assessments in subsection (1) of this section. The health carrier or
6 third-party administrator receiving such abatement or deferment
7 remains liable to the program for the deficiency plus interest at a
8 rate established in the reinsurance plan of operation. Upon receipt
9 of payment of any abatement or deferment by a health carrier or
10 third-party administrator, the board shall adjust future assessments
11 made against other health carriers and third-party administrators
12 under this subsection to reflect receipt of the payment.

13 (6) If the legislature, after receiving the study and
14 recommendations submitted under section 12 of this act, does not
15 enact an alternative financing source for the program on or before
16 June 30, 2019, the board shall determine and collect assessments as
17 provided in this section until the legislature has enacted an
18 alternative financing source.

19 (7) A health carrier or third-party administrator must submit any
20 reports deemed necessary by the board to calculate the assessment
21 under this section in a manner consistent with the schedule and
22 procedures in the plan of operation.

23 NEW SECTION. **Sec. 7.** THIRD-PARTY ADMINISTRATOR—REGISTRATION.
24 (1) A third-party administrator shall register and renew annually
25 with the office of the insurance commissioner, on or before January
26 1, 2019. Registrants shall report a change of legal name, business
27 name, business address, or business telephone number to the
28 commissioner within ten days after the change.

29 (2) The commissioner shall define the data elements and
30 procedures necessary to implement this section and may establish a
31 registration and renewal fees. To minimize administrative burdens on
32 third-party administrators, in developing the data elements and
33 procedures for registration and renewal, the commissioner must, to
34 the extent practicable, adopt the data elements and procedures
35 adopted by the Washington vaccine association under RCW 70.290.075.

36 NEW SECTION. **Sec. 8.** STATE INNOVATION WAIVER APPLICATION. (1)
37 The commissioner must apply to the secretary of health and human
38 services under 42 U.S.C. Sec. 18052 for a state innovation waiver to

implement the Washington reinsurance program for benefit years beginning January 1, 2019, and future years to maximize federal funding. The waiver application must clearly state that operation of the Washington reinsurance program is contingent on approval of the waiver request.

(2) The commissioner must submit the waiver application to the United States secretary of health and human services on or before April 1, 2018. The commissioner must make a draft application available for tribal consultation and for public review and comment by March 1, 2018. The commissioner must notify the chairs and ranking minority members of the house of representatives health care and wellness committee and appropriations committee and the senate health care committee and ways and means committee, and the board of any federal actions regarding the waiver request.

(3) The office of the insurance commissioner must post on its web site any reports submitted to the federal government on the implementation of a waiver granted under this section.

NEW SECTION. **Sec. 9.** CARRIER RATE FILINGS. The commissioner must require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Washington reinsurance program had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

NEW SECTION. **Sec. 10.** REINSURANCE PROGRAM CONTINGENT ON FEDERAL WAIVER. If the state innovation waiver request in section 8 of this act is not approved, or if an approved waiver is terminated or is not renewed, the association and the board may not operate the Washington reinsurance program, collect assessments, or provide reinsurance payments to eligible health carriers.

NEW SECTION. **Sec. 11.** REQUIRED RULE MAKING. The commissioner may adopt rules necessary to carry out this chapter including, but not limited to, rules prescribing the annual establishment of reinsurance payment parameters and measures to enforce reporting of covered lives, audits of covered lives reporting, and payment of applicable assessments.

1 NEW SECTION. **Sec. 12.** ALTERNATIVE FINANCING MECHANISMS. (1) The
2 commissioner, in consultation with the office of financial
3 management, the department of revenue, the health care authority, and
4 the health benefit exchange, shall conduct a study and submit
5 recommendations to the legislature related to alternative financing
6 mechanisms for the Washington reinsurance program. In reviewing
7 alternative financing mechanisms, the commissioner must evaluate the
8 feasibility of a health care paid claims assessment, such as that
9 codified at Michigan Compiled Laws, sections 550.1731 through
10 550.1741.
11 (2) The commissioner must solicit input from interested parties
12 in the course of the study and may contract with third parties for
13 actuarial or economic analysis necessary to fully evaluate
14 alternative financing options. The commissioner must submit his or
15 her report to relevant committees of the legislature on or before
16 November 30, 2018.
17 (3) If additional federal funding to support administration and
18 implementation of state-based reinsurance programs becomes available
19 to states, distinct from an application submitted under section 8 of
20 this act, the commissioner shall notify the relevant policy and
21 fiscal committees of the legislature and pursue such funding to
22 offset assessments associated with the reinsurance program
23 established in this chapter.

24 NEW SECTION. **Sec. 13.** CIVIL AND CRIMINAL IMMUNITY. The program,
25 health carriers and third-party administrators assessed by the
26 program, the board, officers of the program, employees of the
27 program, contractors of the program and the contractors' employees,
28 officers, and directors, the commissioner, the commissioner's
29 representatives, and the commissioner's employees are not civilly or
30 criminally liable and may not have any penalty or cause of action of
31 any nature arise against them for any action or inaction, including
32 any discretionary decision or failure to make a discretionary
33 decision, when the action or inaction is done in good faith and in
34 the performance of the powers and duties under this chapter. This
35 section does not prohibit legal actions against the program to
36 enforce the program's statutory or contractual duties or obligations.

37 NEW SECTION. **Sec. 14.** (1) The legislature finds that:

(a) The continuing viability of the Washington state health insurance pool is essential to achieving the goals of the Washington reinsurance program;

(b) It is therefore essential that the Washington state health insurance pool have a broad, stable funding source; and

(c) It is also essential to minimize the administrative complexity of the two programs on entities subject to dual assessments.

(2) It is therefore the intent of the legislature to maximize the market stabilizing effects of the Washington reinsurance program by:

(a) Broadening the assessment base for the Washington state health insurance pool; and

(b) Allowing entities subject to assessment by both the Washington reinsurance program and the Washington state health insurance pool to pay their assessments through one combined bill.

NEW SECTION. **Sec. 15.** (1) The board shall add any assessments received from the Washington state health insurance pool under RCW 48.41.090 to the assessments calculated under section 6 of this act. The board shall collect the assessment, on behalf of the Washington state health insurance pool, on the next date collections for assessments levied under section 6 of this act are due. The board shall work with the Washington state health insurance pool to synchronize assessment dates for the programs.

(2) Upon receipt of the assessments levied under subsection (1) of this section, the board shall remit any amounts collected on behalf of the Washington state health insurance pool to the Washington state health insurance pool.

Sec. 16. RCW 48.41.030 and 2004 c 260 s 25 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Accounting year" means a twelve-month period determined by the board for purposes of recordkeeping and accounting. The first accounting year may be more or less than twelve months and, from time to time in subsequent years, the board may order an accounting year of other than twelve months as may be required for orderly management and accounting of the pool.

1 (2) "Administrator" means the entity chosen by the board to
2 administer the pool under RCW 48.41.080.
3 (3) "Board" means the board of directors of the pool.
4 (4) "Commissioner" means the insurance commissioner.
5 (5) "Covered person" means any individual resident of this state
6 who is eligible to receive benefits from any member, or other health
7 plan.
8 (6) "Health care facility" has the same meaning as in RCW
9 70.38.025.
10 (7) "Health care provider" means any physician, facility, or
11 health care professional, who is licensed in Washington state and
12 entitled to reimbursement for health care services.
13 (8) "Health care services" means services for the purpose of
14 preventing, alleviating, curing, or healing human illness or injury.
15 (9) "Health carrier" or "carrier" has the same meaning as in RCW
16 48.43.005.
17 (10) "Health coverage" means any group or individual disability
18 insurance policy, health care service contract, and health
19 maintenance agreement, except those contracts entered into for the
20 provision of health care services pursuant to Title XVIII of the
21 Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not
22 include short-term care, long-term care, dental, vision, accident,
23 fixed indemnity, disability income contracts, limited benefit or
24 credit insurance, coverage issued as a supplement to liability
25 insurance, insurance arising out of the worker's compensation or
26 similar law, automobile medical payment insurance, or insurance under
27 which benefits are payable with or without regard to fault and which
28 is statutorily required to be contained in any liability insurance
29 policy or equivalent self-insurance.
30 (11) "Health plan" means any arrangement by which persons,
31 including dependents or spouses, covered or making application to be
32 covered under this pool, have access to hospital and medical benefits
33 or reimbursement including any group or individual disability
34 insurance policy; health care service contract; health maintenance
35 agreement; uninsured arrangements of group or group-type contracts
36 including employer self-insured, cost-plus, or other benefit
37 methodologies not involving insurance or not governed by Title 48
38 RCW; coverage under group-type contracts which are not available to
39 the general public and can be obtained only because of connection
40 with a particular organization or group; and coverage by medicare or

other governmental benefits. This term includes coverage through "health coverage" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health coverage" in subsection (10) of this section.

(12) "Medical assistance" means coverage under Title XIX of the federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and chapter 74.09 RCW.

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

(14) "Member" means ((~~any commercial insurer which provides disability insurance or stop loss insurance, any health care service contractor, any health maintenance organization licensed under Title 48 RCW, and any self-funded multiple employer welfare arrangement as defined in RCW 48.125.010. "Member" also means the Washington state health care authority as issuer of the state uniform medical plan. "Member" shall also mean, as soon as authorized by federal law, employers and other entities, including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after May 18, 1987. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products or those products excluded from the definition of "health coverage" set forth in subsection (10) of this section~~)) a health carrier or third-party administrator subject to a covered life assessment under section 6 of this act or a managed health care system as defined in RCW 74.09.522.

(15) "Network provider" means a health care provider who has contracted in writing with the pool administrator or a health carrier contracting with the pool administrator to offer pool coverage to accept payment from and to look solely to the pool or health carrier according to the terms of the pool health plans.

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

(17) "Point of service plan" means a benefit plan offered by the pool under which a covered person may elect to receive covered services from network providers, or nonnetwork providers at a reduced rate of benefits.

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

Sec. 17. RCW 48.41.090 and 2013 2nd sp.s. c 6 s 7 are each amended to read as follows:

(1) Following the close of each accounting year, the pool administrator shall determine the total net cost of pool operation which shall include:

(a) Net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses; and

(b) The amount of pool contributions specified in the state omnibus appropriations act for deposit into the health benefit exchange account under RCW 43.71.060, to assist with the transition of enrollees from the pool into the health benefit exchange created by chapter 43.71 RCW.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction. The numerator of the fraction equals that member's total number of resident insured persons, including spouse and dependents, covered under all health plans in the state by that member during the preceding calendar year. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, covered under all health plans in the state by all pool members during the preceding calendar year.

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

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

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

~~(iii)~~)), health plans serving medical care services program clients under RCW 74.09.035 are exempted from the calculation((~~; and~~

~~(iv) Health plans established to serve elderly clients or medicaid clients with disabilities under chapter 74.09 RCW when the plan has been implemented on a demonstration or pilot project basis are exempted from the calculation until July 1, 2009~~)).

(c) Except as provided in RCW 48.41.037, any deficit incurred by the pool, including pool contributions for deposit into the health benefit exchange account, shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members. The monthly per member assessment may not exceed the 2013 assessment level. If the maximum assessment is insufficient to cover a pool deficit the assessment shall be used first to pay all incurred losses and pool administrative expenses, with the remainder being available for deposit in the health benefit exchange account.

(3) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (2) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency.

(4) The pool administrator shall notify the Washington reinsurance program created in section 2 of this act of the pool assessment amounts owed by members who are subject to assessment by both the Washington reinsurance program and the pool. Pool assessments owed by members who are subject to assessments by both the Washington reinsurance program and the pool must be collected and remitted back to the pool under section 15 of this act.

(5) Subject to the limitation imposed in subsection (2)(c) of this section, the pool administrator shall transfer the assessments for pool contributions for the operation of the health benefit exchange to the treasurer for deposit into the health benefit exchange account with the quarterly assessments for 2014 as specified in the state omnibus appropriations act. If assessments exceed actual losses and administrative expenses of the pool and pool contributions for deposit into the health benefit exchange account, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

Sec. 18. RCW 42.56.400 and 2017 3rd sp.s. c 30 s 2 and 2017 c 193 s 2 are each reenacted and amended to read as follows:

The following information relating to insurance and financial institutions is exempt from disclosure under this chapter:

(1) Records maintained by the board of industrial insurance appeals that are related to appeals of crime victims' compensation claims filed with the board under RCW 7.68.110;

(2) Information obtained and exempted or withheld from public inspection by the health care authority under RCW 41.05.026, whether retained by the authority, transferred to another state purchased health care program by the authority, or transferred by the authority to a technical review committee created to facilitate the development, acquisition, or implementation of state purchased health care under chapter 41.05 RCW;

(3) The names and individual identification data of either all owners or all insureds, or both, received by the insurance commissioner under chapter 48.102 RCW;

(4) Information provided under RCW 48.30A.045 through 48.30A.060;

(5) Information provided under RCW 48.05.510 through 48.05.535, 48.43.200 through 48.43.225, 48.44.530 through 48.44.555, and 48.46.600 through 48.46.625;

(6) Examination reports and information obtained by the department of financial institutions from banks under RCW 30A.04.075, from savings banks under RCW 32.04.220, from savings and loan associations under RCW 33.04.110, from credit unions under RCW 31.12.565, from check cashers and sellers under RCW 31.45.030(3), and from securities brokers and investment advisers under RCW 21.20.100, all of which is confidential and privileged information;

(7) Information provided to the insurance commissioner under RCW 48.110.040(3);

(8) Documents, materials, or information obtained by the insurance commissioner under RCW 48.02.065, all of which are confidential and privileged;

(9) Documents, materials, or information obtained by the insurance commissioner under RCW 48.31B.015(2) (l) and (m), 48.31B.025, 48.31B.030, and 48.31B.035, all of which are confidential and privileged;

(10) Data filed under RCW 48.140.020, 48.140.030, 48.140.050, and 7.70.140 that, alone or in combination with any other data, may reveal the identity of a claimant, health care provider, health care

facility, insuring entity, or self-insurer involved in a particular claim or a collection of claims. For the purposes of this subsection:

(a) "Claimant" has the same meaning as in RCW 48.140.010(2).

(b) "Health care facility" has the same meaning as in RCW 48.140.010(6).

(c) "Health care provider" has the same meaning as in RCW 48.140.010(7).

(d) "Insuring entity" has the same meaning as in RCW 48.140.010(8).

(e) "Self-insurer" has the same meaning as in RCW 48.140.010(11);

(11) Documents, materials, or information obtained by the insurance commissioner under RCW 48.135.060;

(12) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.060;

(13) Confidential and privileged documents obtained or produced by the insurance commissioner and identified in RCW 48.37.080;

(14) Documents, materials, or information obtained by the insurance commissioner under RCW 48.37.140;

(15) Documents, materials, or information obtained by the insurance commissioner under RCW 48.17.595;

(16) Documents, materials, or information obtained by the insurance commissioner under RCW 48.102.051(1) and 48.102.140 (3) and (7)(a)(ii);

(17) Documents, materials, or information obtained by the insurance commissioner in the commissioner's capacity as receiver under RCW 48.31.025 and 48.99.017, which are records under the jurisdiction and control of the receivership court. The commissioner is not required to search for, log, produce, or otherwise comply with the public records act for any records that the commissioner obtains under chapters 48.31 and 48.99 RCW in the commissioner's capacity as a receiver, except as directed by the receivership court;

(18) Documents, materials, or information obtained by the insurance commissioner under RCW 48.13.151;

(19) Data, information, and documents provided by a carrier pursuant to section 1, chapter 172, Laws of 2010;

(20) Information in a filing of usage-based insurance about the usage-based component of the rate pursuant to RCW 48.19.040(5)(b);

(21) Data, information, and documents, other than those described in RCW 48.02.210(2), that are submitted to the office of the

insurance commissioner by an entity providing health care coverage pursuant to RCW 28A.400.275 and 48.02.210;

(22) Data, information, and documents obtained by the insurance commissioner under RCW 48.29.017;

(23) Information not subject to public inspection or public disclosure under RCW 48.43.730(5);

(24) Documents, materials, or information obtained by the insurance commissioner under chapter 48.05A RCW;

(25) Documents, materials, or information obtained by the insurance commissioner under RCW 48.74.025, 48.74.028, 48.74.100(6), 48.74.110(2) (b) and (c), and 48.74.120 to the extent such documents, materials, or information independently qualify for exemption from disclosure as documents, materials, or information in possession of the commissioner pursuant to a financial conduct examination and exempt from disclosure under RCW 48.02.065; ((~~and~~))

(26) Nonpublic personal health information obtained by, disclosed to, or in the custody of the insurance commissioner, as provided in RCW 48.02.068; ((~~and~~))

(27) Data, information, and documents obtained by the insurance commissioner under RCW 48.02.230;

(28) Data, information, and documents necessary to prepare the state innovation waiver application submitted under section 8 of this act, to determine reinsurance parameters obtained by the commissioner under section 5 of this act and to determine reinsurance claims payments; and

(29) Claims submitted under section 5 of this act.

NEW SECTION. **Sec. 19.** CODIFICATION. Sections 1 through 13 and 15 of this act constitute a new chapter in Title 48 RCW.

NEW SECTION. **Sec. 20.** SEVERABILITY. 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.

NEW SECTION. **Sec. 21.** EMERGENCY EFFECTIVE DATE. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately."

1 Correct the title.

EFFECT: Changes the membership of the Washington Reinsurance Management Board (Board). Adds a member representing Taft-Hartley trusts to the Board. Adds a nonvoting member representing the Washington Health Benefit Exchange to the Board. Makes the Insurance Commissioner (or designee) a nonvoting member of the Board, instead of a voting member.

Allows, prior to the appointment of the Board, the Washington Vaccine Association (WVA) to contract with an administrator for reinsurance planning and development. Allows the Board's annual financial report to be posted on a Washington Reinsurance Program (WRP) web site established by the Board. Requires the reinsurance plan of operation to provide for the segregation of funds used to fund the WRP from funds used for the WVA.

Changes the attestation that reinsurance-eligible carriers must submit regarding care management. Requires the attestation to describe the procedures by which enrollees will be offered the opportunity to participate in care management strategies for which the enrollee is eligible, instead of committing to offer each enrollee the opportunity to participate.

Changes the manner in which assessments are calculated and levied. Allows the 2019 assessments to include start-up costs incurred in 2018 for development of the WRP. Requires a carrier's or third-party administrator's (TPA's) assessment to be calculated, instead of by applying a fraction to net assessments, by multiplying the carrier's or TPAs covered lives by a covered life assessment rate, which is the net assessment amount divided by the total number of covered lives reported by all carriers and TPAs. Requires the covered life assessment rate (instead of the assessment amount) to be approved by the Insurance Commissioner (Commissioner by October 15, 2018, and May 25th of subsequent years). Requires payments to be calculated and paid on a quarterly basis.

Removes the Washington Reinsurance Program Account.

States the Legislature's intent to maximize the market stabilizing effects of the WRP by broadening the assessment base for the Washington State Health Insurance Pool (WSHIP) and by allowing entities subject to assessments by both programs to pay their assessments in one bill. Restores the obligation of Medicaid Managed Care Organizations to pay WSHIP assessments. Restores the exemption from WSHIP assessments for health plans serving Medical Care Services Program clients. Clarifies that single billing requirement only applies to entities subject to assessments by both the WRP and the WSHIP.

Removes changes made to the Public Records Act regarding the report on school district health benefits.

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