
SUBSTITUTE SENATE BILL 6178

State of Washington

62nd Legislature

2012 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser, Conway, Shin, Frockt, Kline, Pflug, and Chase; by request of Governor Gregoire and Insurance Commissioner)

READ FIRST TIME 02/02/12.

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 43.71.010, 43.71.020, 43.71.030, 43.71.060, 48.42.010,
4 48.42.020, 48.41.060, 48.41.110, and 48.41.170; reenacting and amending
5 RCW 48.43.005; adding new sections to chapter 48.43 RCW; adding new
6 sections to chapter 43.71 RCW; adding a new section to chapter 70.47
7 RCW; adding new sections to chapter 48.41 RCW; repealing RCW 48.43.018,
8 48.41.020, 48.41.100, and 48.41.200; prescribing penalties; providing
9 effective dates; and declaring an emergency.

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

11 **PART I**
12 **DEFINITIONS**

13 **Sec. 1.** RCW 48.43.005 and 2011 c 315 s 2 and 2011 c 314 s 3 are
14 each reenacted and amended to read as follows:

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

17 (1) "Adjusted community rate" means the rating method used to

1 establish the premium for health plans adjusted to reflect actuarially
2 demonstrated differences in utilization or cost attributable to
3 geographic region, age, family size, and use of wellness activities.

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

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

19 (4) "Basic health plan" means the plan described under chapter
20 70.47 RCW, as revised from time to time.

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

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

27 (7) "Board" means the governing board of the Washington health
28 benefit exchange established in chapter 43.71 RCW.

29 (8)(a) For grandfathered health benefit plans issued before January
30 1, 2014, and renewed thereafter, "catastrophic health plan" means:

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

1 ~~((b))~~ (ii) In the case of a contract, agreement, or policy
2 covering more than one enrollee, a health benefit plan requiring a
3 calendar year deductible of, at a minimum, three thousand five hundred
4 dollars and an annual out-of-pocket expense required to be paid under
5 the plan (other than for premiums) for covered benefits of at least six
6 thousand dollars, both amounts to be adjusted annually by the insurance
7 commissioner(~~or~~

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

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

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

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

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

30 ~~((8))~~ (9) "Certification" means a determination by a review
31 organization that an admission, extension of stay, or other health care
32 service or procedure has been reviewed and, based on the information
33 provided, meets the clinical requirements for medical necessity,
34 appropriateness, level of care, or effectiveness under the auspices of
35 the applicable health benefit plan.

36 ~~((9))~~ (10) "Concurrent review" means utilization review conducted
37 during a patient's hospital stay or course of treatment.

1 ~~((+10+))~~ (11) "Covered person" or "enrollee" means a person covered
2 by a health plan including an enrollee, subscriber, policyholder,
3 beneficiary of a group plan, or individual covered by any other health
4 plan.

5 ~~((+11+))~~ (12) "Dependent" means, at a minimum, the enrollee's legal
6 spouse and dependent children who qualify for coverage under the
7 enrollee's health benefit plan.

8 ~~((+12+))~~ (13) "Emergency medical condition" means a medical
9 condition manifesting itself by acute symptoms of sufficient severity,
10 including severe pain, such that a prudent layperson, who possesses an
11 average knowledge of health and medicine, could reasonably expect the
12 absence of immediate medical attention to result in a condition (a)
13 placing the health of the individual, or with respect to a pregnant
14 woman, the health of the woman or her unborn child, in serious
15 jeopardy, (b) serious impairment to bodily functions, or (c) serious
16 dysfunction of any bodily organ or part.

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

29 ~~((+14+))~~ (15) "Employee" has the same meaning given to the term, as
30 of January 1, 2008, under section 3(6) of the federal employee
31 retirement income security act of 1974.

32 ~~((+15+))~~ (16) "Enrollee point-of-service cost-sharing" means
33 amounts paid to health carriers directly providing services, health
34 care providers, or health care facilities by enrollees and may include
35 copayments, coinsurance, or deductibles.

36 ~~((+16+))~~ (17) "Exchange" means the Washington health benefit
37 exchange established under chapter 43.71 RCW.

1 (18) "Final external review decision" means a determination by an
2 independent review organization at the conclusion of an external
3 review.

4 ~~((+17))~~ (19) "Final internal adverse benefit determination" means
5 an adverse benefit determination that has been upheld by a health plan
6 or carrier at the completion of the internal appeals process, or an
7 adverse benefit determination with respect to which the internal
8 appeals process has been exhausted under the exhaustion rules described
9 in RCW 48.43.530 and 48.43.535.

10 ~~((+18))~~ (20) "Grandfathered health plan" means a group health plan
11 or an individual health plan that under section 1251 of the patient
12 protection and affordable care act, P.L. 111-148 (2010) and as amended
13 by the health care and education reconciliation act, P.L. 111-152
14 (2010) is not subject to subtitles A or C of the act as amended.

15 ~~((+19))~~ (21) "Grievance" means a written complaint submitted by or
16 on behalf of a covered person regarding: (a) Denial of payment for
17 medical services or nonprovision of medical services included in the
18 covered person's health benefit plan, or (b) service delivery issues
19 other than denial of payment for medical services or nonprovision of
20 medical services, including dissatisfaction with medical care, waiting
21 time for medical services, provider or staff attitude or demeanor, or
22 dissatisfaction with service provided by the health carrier.

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

36 ~~((+21))~~ (23) "Health care provider" or "provider" means:

37 (a) A person regulated under Title 18 or chapter 70.127 RCW, to

1 practice health or health-related services or otherwise practicing
2 health care services in this state consistent with state law; or

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

5 ~~((+22+))~~ (24) "Health care service" means that service offered or
6 provided by health care facilities and health care providers relating
7 to the prevention, cure, or treatment of illness, injury, or disease.

8 ~~((+23+))~~ (25) "Health carrier" or "carrier" means a disability
9 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
10 service contractor as defined in RCW 48.44.010, or a health maintenance
11 organization as defined in RCW 48.46.020, and includes "issuers" as
12 that term is used in the patient protection and affordable care act
13 (P.L. 111-148).

14 ~~((+24+))~~ (26) "Health plan" or "health benefit plan" means any
15 policy, contract, or agreement offered by a health carrier to provide,
16 arrange, reimburse, or pay for health care services except the
17 following:

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

20 (b) Medicare supplemental health insurance governed by chapter
21 48.66 RCW;

22 (c) Coverage supplemental to the coverage provided under chapter
23 55, Title 10, United States Code;

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

26 (e) Disability income;

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

30 (g) Workers' compensation coverage;

31 (h) Accident only coverage;

32 (i) Specified disease or illness-triggered fixed payment insurance,
33 hospital confinement fixed payment insurance, or other fixed payment
34 insurance offered as an independent, noncoordinated benefit;

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

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

37 (l) Plans deemed by the insurance commissioner to have a short-term
38 limited purpose or duration, or to be a student-only plan that is

1 guaranteed renewable while the covered person is enrolled as a regular
2 full-time undergraduate or graduate student at an accredited higher
3 education institution, after a written request for such classification
4 by the carrier and subsequent written approval by the insurance
5 commissioner.

6 ~~((+25+))~~ (27) "Material modification" means a change in the
7 actuarial value of the health plan as modified of more than five
8 percent but less than fifteen percent.

9 ~~((+26+))~~ (28) "Open enrollment" means a period of time as defined
10 in rule to be held at the same time each year, during which applicants
11 may enroll in a carrier's individual health benefit plan without being
12 subject to health screening or otherwise required to provide evidence
13 of insurability as a condition for enrollment.

14 ~~((+27+))~~ (29) "Preexisting condition" means any medical condition,
15 illness, or injury that existed any time prior to the effective date of
16 coverage.

17 ~~((+28+))~~ (30) "Premium" means all sums charged, received, or
18 deposited by a health carrier as consideration for a health plan or the
19 continuance of a health plan. Any assessment or any "membership,"
20 "policy," "contract," "service," or similar fee or charge made by a
21 health carrier in consideration for a health plan is deemed part of the
22 premium. "Premium" shall not include amounts paid as enrollee point-
23 of-service cost-sharing.

24 ~~((+29+))~~ (31) "Review organization" means a disability insurer
25 regulated under chapter 48.20 or 48.21 RCW, health care service
26 contractor as defined in RCW 48.44.010, or health maintenance
27 organization as defined in RCW 48.46.020, and entities affiliated with,
28 under contract with, or acting on behalf of a health carrier to perform
29 a utilization review.

30 ~~((+30+))~~ (32) "Small employer" or "small group" means any person,
31 firm, corporation, partnership, association, political subdivision,
32 sole proprietor, or self-employed individual that is actively engaged
33 in business that employed an average of at least one but no more than
34 fifty employees, during the previous calendar year and employed at
35 least one employee on the first day of the plan year, is not formed
36 primarily for purposes of buying health insurance, and in which a bona
37 fide employer-employee relationship exists. In determining the number
38 of employees, companies that are affiliated companies, or that are

1 eligible to file a combined tax return for purposes of taxation by this
2 state, shall be considered an employer. Subsequent to the issuance of
3 a health plan to a small employer and for the purpose of determining
4 eligibility, the size of a small employer shall be determined annually.
5 Except as otherwise specifically provided, a small employer shall
6 continue to be considered a small employer until the plan anniversary
7 following the date the small employer no longer meets the requirements
8 of this definition. A self-employed individual or sole proprietor who
9 is covered as a group of one must also: (a) Have been employed by the
10 same small employer or small group for at least twelve months prior to
11 application for small group coverage, and (b) verify that he or she
12 derived at least seventy-five percent of his or her income from a trade
13 or business through which the individual or sole proprietor has
14 attempted to earn taxable income and for which he or she has filed the
15 appropriate internal revenue service form 1040, schedule C or F, for
16 the previous taxable year, except a self-employed individual or sole
17 proprietor in an agricultural trade or business, must have derived at
18 least fifty-one percent of his or her income from the trade or business
19 through which the individual or sole proprietor has attempted to earn
20 taxable income and for which he or she has filed the appropriate
21 internal revenue service form 1040, for the previous taxable year.

22 ~~((+31+))~~ (33) "Special enrollment" means a defined period of time
23 of not less than thirty-one days, triggered by a specific qualifying
24 event experienced by the applicant, during which applicants may enroll
25 in the carrier's individual health benefit plan without being subject
26 to health screening or otherwise required to provide evidence of
27 insurability as a condition for enrollment.

28 ~~((+32+))~~ (34) "Standard health questionnaire" means the standard
29 health questionnaire designated under chapter 48.41 RCW.

30 ~~((+33+))~~ (35) "Utilization review" means the prospective,
31 concurrent, or retrospective assessment of the necessity and
32 appropriateness of the allocation of health care resources and services
33 of a provider or facility, given or proposed to be given to an enrollee
34 or group of enrollees.

35 ~~((+34+))~~ (36) "Wellness activity" means an explicit program of an
36 activity consistent with department of health guidelines, such as,
37 smoking cessation, injury and accident prevention, reduction of alcohol
38 misuse, appropriate weight reduction, exercise, automobile and

1 motorcycle safety, blood cholesterol reduction, and nutrition education
2 for the purpose of improving enrollee health status and reducing health
3 service costs.

4 **PART II**

5 **THE WASHINGTON HEALTH BENEFIT EXCHANGE**

6 **Sec. 2.** RCW 43.71.010 and 2011 c 317 s 2 are each amended to read
7 as follows:

8 The definitions in this section apply throughout this chapter
9 unless the context clearly requires otherwise. Terms and phrases used
10 in this chapter that are not defined in this section must be defined as
11 consistent with implementation of a state health benefit exchange
12 pursuant to the affordable care act.

13 (1) "Affordable care act" means the federal patient protection and
14 affordable care act, P.L. 111-148, as amended by the federal health
15 care and education reconciliation act of 2010, P.L. 111-152, or federal
16 regulations or guidance issued under the affordable care act.

17 (2) "Authority" means the Washington state health care authority,
18 established under chapter 41.05 RCW.

19 (3) "Board" means the governing board established in RCW 43.71.020.

20 (4) "Commissioner" means the insurance commissioner, established in
21 Title 48 RCW.

22 (5) "Exchange" means the Washington health benefit exchange
23 established in RCW 43.71.020.

24 (6) "Self-sustaining" means capable of operating without direct
25 state tax subsidy from sources including but not limited to federal
26 grants, federal premium tax subsidies and credits, charges to insurance
27 carriers, and premiums paid by participating enrollees.

28 **Sec. 3.** RCW 43.71.020 and 2011 c 317 s 3 are each amended to read
29 as follows:

30 (1) The Washington health benefit exchange is established and
31 constitutes a self-sustaining public-private partnership separate and
32 distinct from the state, exercising functions delineated in chapter
33 317, Laws of 2011. By January 1, 2014, the exchange shall operate
34 consistent with the affordable care act subject to statutory
35 authorization. The exchange shall have a governing board consisting of

1 persons with expertise in the Washington health care system and private
2 and public health care coverage. The initial membership of the board
3 shall be appointed as follows:

4 (a) By October 1, 2011, each of the two largest caucuses in both
5 the house of representatives and the senate shall submit to the
6 governor a list of five nominees who are not legislators or employees
7 of the state or its political subdivisions, with no caucus submitting
8 the same nominee.

9 (i) The nominations from the largest caucus in the house of
10 representatives must include at least one employee benefit specialist;

11 (ii) The nominations from the second largest caucus in the house of
12 representatives must include at least one health economist or actuary;

13 (iii) The nominations from the largest caucus in the senate must
14 include at least one representative of health consumer advocates;

15 (iv) The nominations from the second largest caucus in the senate
16 must include at least one representative of small business;

17 (v) The remaining nominees must have demonstrated and acknowledged
18 expertise in at least one of the following areas: Individual health
19 care coverage, small employer health care coverage, health benefits
20 plan administration, health care finance and economics, actuarial
21 science, or administering a public or private health care delivery
22 system.

23 (b) By December 15, 2011, the governor shall appoint two members
24 from each list submitted by the caucuses under (a) of this subsection.
25 The appointments made under this subsection (1)(b) must include at
26 least one employee benefits specialist, one health economist or
27 actuary, one representative of small business, and one representative
28 of health consumer advocates. The remaining four members must have a
29 demonstrated and acknowledged expertise in at least one of the
30 following areas: Individual health care coverage, small employer
31 health care coverage, health benefits plan administration, health care
32 finance and economics, actuarial science, or administering a public or
33 private health care delivery system.

34 (c) By December 15, 2011, the governor shall appoint a ninth member
35 to serve as chair. The chair may not be an employee of the state or
36 its political subdivisions. The chair shall serve as a nonvoting
37 member except in the case of a tie.

1 (d) The following members shall serve as nonvoting, ex officio
2 members of the board:

3 (i) The insurance commissioner or his or her designee; and

4 (ii) The administrator of the health care authority, or his or her
5 designee.

6 (2) Initial members of the board shall serve staggered terms not to
7 exceed four years. Members appointed thereafter shall serve two-year
8 terms.

9 (3) A member of the board whose term has expired or who otherwise
10 leaves the board shall be replaced by gubernatorial appointment. When
11 the person leaving was nominated by one of the caucuses of the house of
12 representatives or the senate, his or her replacement shall be
13 appointed from a list of five nominees submitted by that caucus within
14 thirty days after the person leaves. If the member to be replaced is
15 the chair, the governor shall appoint a new chair within thirty days
16 after the vacancy occurs. A person appointed to replace a member who
17 leaves the board prior to the expiration of his or her term shall serve
18 only the duration of the unexpired term. Members of the board may be
19 reappointed to multiple terms.

20 (4) No board member may be appointed if his or her participation in
21 the decisions of the board could benefit his or her own financial
22 interests or the financial interests of an entity he or she represents.
23 A board member who develops such a conflict of interest shall resign or
24 be removed from the board.

25 (5) Members of the board must be reimbursed for their travel
26 expenses while on official business in accordance with RCW 43.03.050
27 and 43.03.060. The board shall prescribe rules for the conduct of its
28 business. Meetings of the board are at the call of the chair.

29 (6) The exchange and the board are subject only to the provisions
30 of chapter 42.30 RCW, the open public meetings act, and chapter 42.56
31 RCW, the public records act, and not to any other law or regulation
32 generally applicable to state agencies. Consistent with the open
33 public meetings act, the board may hold executive sessions to consider
34 proprietary or confidential nonpublished information.

35 (7)(a) The board shall establish an advisory committee to allow for
36 the views of the health care industry and other stakeholders to be
37 heard in the operation of the health benefit exchange.

1 (b) The board may establish technical advisory committees or seek
2 the advice of technical experts when necessary to execute the powers
3 and duties included in chapter 317, Laws of 2011.

4 (8) Members of the board are not civilly or criminally liable and
5 may not have any penalty or cause of action of any nature arise against
6 them for any action taken or not taken, including any discretionary
7 decision or failure to make a discretionary decision, when the action
8 or inaction is done in good faith and in the performance of the powers
9 and duties under chapter 317, Laws of 2011. Nothing in this section
10 prohibits legal actions against the board to enforce the board's
11 statutory or contractual duties or obligations.

12 (9) In recognition of the government-to-government relationship
13 between the state of Washington and the federally recognized tribes in
14 the state of Washington, the board shall consult with the American
15 Indian health commission.

16 **Sec. 4.** RCW 43.71.030 and 2011 c 317 s 4 are each amended to read
17 as follows:

18 (1) The exchange may, consistent with the purposes of this chapter:
19 (a) Sue and be sued in its own name; (b) make and execute agreements,
20 contracts, and other instruments, with any public or private person or
21 entity; (c) employ, contract with, or engage personnel; (d) pay
22 administrative costs; ~~((and))~~ (e) consider aggregating or delegating
23 the aggregation of funds that comprise the premium for a health plan;
24 (f) accept grants, donations, loans of funds, and contributions in
25 money, services, materials or otherwise, from the United States or any
26 of its agencies, from the state of Washington and its agencies or from
27 any other source, and use or expend those moneys, services, materials,
28 or other contributions; and (g) complete other duties as may be
29 necessary to comply with the requirements of section 1321 of P.L.
30 111-148 of 2010, as amended.

31 ~~((The powers and duties of the exchange and the board are~~
32 ~~limited to those necessary to apply for and administer grants,~~
33 ~~establish information technology infrastructure, and undertake~~
34 ~~additional administrative functions necessary to begin operation of the~~
35 ~~exchange by January 1, 2014. Any actions relating to substantive~~
36 ~~issues included in RCW 43.71.040 must be consistent with statutory~~

1 ~~direction on those issues.))~~ The exchange shall report its activities
2 and status to the governor and the legislature as requested, and no
3 less often than annually.

4 (3) The exchange may charge and equitably apportion among
5 participating carriers the administrative costs and expenses incurred
6 consistent with the provisions of this chapter, and must develop the
7 methodology to ensure the exchange is self-sustaining.

8 (4) The exchange must prepare recommendations to the legislature on
9 future opportunity to establish a regionally administered multistate
10 exchange, as well as recommendations on the effective implementation of
11 risk management methods including administration of reinsurance, risk
12 corridors, and risk adjustment.

13 (5) Any actions relating to substantive issues identified in this
14 section must be consistent with statutory direction.

15 **Sec. 5.** RCW 43.71.060 and 2011 c 317 s 7 are each amended to read
16 as follows:

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

28 **PART III**
29 **MARKET RULES**

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

32 (1) A carrier may not offer any individual health benefit plan
33 outside the Washington health benefit exchange that meets the
34 definition of a bronze level qualified health plan under section 1302

1 of P.L. 111-148 of 2010, as amended, unless the carrier also offers a
2 silver level and gold level individual qualified health plan.

3 (2) A carrier may not offer any small group health benefit plan
4 outside the Washington health benefit exchange that meets the
5 definition of a bronze level qualified health plan under section 1302
6 of P.L. 111-148 of 2010, as amended, unless the carrier also offers a
7 silver level and gold level small group qualified health plan.

8 (3)(a) The commissioner, in consultation with the exchange and the
9 health care authority, may adopt rules requiring a carrier to offer a
10 plan that meets the definition of a bronze level plan outside the
11 exchange if they offer a bronze level plan inside the exchange.

12 (b) Subsections (1) and (2) of this section expire January 1, 2016,
13 and rules drafted for (a) of this subsection expire January 1, 2016.

14 (4) If the commissioner finds the consumers in the exchange do not
15 have an adequate choice of health plan options among the actuarial
16 value tiers specified in section 1302 of P.L. 111-148 in the exchange,
17 the commissioner in consultation with the exchange board, may authorize
18 the offering of a public plan and pursue the opportunity for a waiver
19 under section 1332 of P.L. 111-148 of 2010, as amended.

20 NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW
21 to read as follows:

22 All health plans, other than catastrophic health plans, offered
23 outside of the exchange must conform with the actuarial value tiers
24 specified in section 1302 of P.L. 111-148, as amended, as bronze,
25 silver, gold, or platinum.

26 **PART IV**

27 **QUALIFIED HEALTH PLANS**

28 NEW SECTION. **Sec. 8.** A new section is added to chapter 43.71 RCW
29 to read as follows:

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

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

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

3 (c) Is determined by the board to include tribal clinics and urban
4 Indian clinics as essential community providers in the plan's provider
5 network.

6 (2) Consistent with federal law, the board shall allow a stand-
7 alone dental plan to offer coverage in the exchange.

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

15 (4) A decision by the board denying a request to certify or
16 recertify a plan as a qualified health plan may be appealed according
17 to procedures adopted by the board.

18 NEW SECTION. **Sec. 9.** A new section is added to chapter 43.71 RCW
19 to read as follows:

20 The board shall establish a rating system for qualified health
21 plans to assist consumers in evaluating plan choices in the exchange.
22 Rating factors established by the board must include, but are not
23 limited to:

24 (1) Affordability with respect to premiums, deductibles, and point-
25 of-service cost-sharing;

26 (2) Provider reimbursement methods that incentivize chronic care
27 management and care coordination for enrollees with complex, high-cost,
28 or multiple chronic conditions;

29 (3) Promotion of appropriate primary care and preventive services
30 utilization; and

31 (4) High standards for provider network adequacy, including robust
32 provider participation intended to improve access to underserved
33 populations through participation of essential community providers,
34 family planning providers and pediatric providers.

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

1 (1) Notwithstanding any other provision of law, and except as
2 provided in this chapter, any person or other entity which provides
3 coverage in this state for life insurance, annuities, loss of time,
4 medical, surgical, chiropractic, physical therapy, speech pathology,
5 audiology, professional mental health, dental, hospital, or optometric
6 expenses, whether the coverage is by direct payment, reimbursement, the
7 providing of services, or otherwise, shall be subject to the authority
8 of the state insurance commissioner, unless the person or other entity
9 shows that while providing the services it is subject to the
10 jurisdiction and regulation of another agency of this state, any
11 subdivisions thereof, or the federal government.

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

15 **Sec. 11.** RCW 48.42.020 and 1983 c 36 s 2 are each amended to read
16 as follows:

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

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

26 **NEW SECTION.** Sec. 12. A new section is added to chapter 48.43 RCW
27 to read as follows:

28 Certification by the Washington health benefit exchange of a plan
29 as a qualified health plan, or of a carrier as a qualified issuer, does
30 not exempt the plan or carrier from any of the requirements of this
31 title or rules adopted by the commissioner pursuant to chapter 34.05
32 RCW.

33 **PART V**
34 **ESSENTIAL HEALTH BENEFITS**

1 NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43 RCW
2 to read as follows:

3 (1) Consistent with federal law, the commissioner, in consultation
4 with the board and the health care authority, shall, by rule, select a
5 benchmark plan for purposes of establishing the essential health
6 benefits in Washington state under P.L. 111-148 of 2010, as amended.
7 The commissioner shall make his or her selection from the following
8 options:

9 (a) The three largest small group plans in the state by enrollment;
10 or

11 (b) The largest health maintenance organization in the state's
12 commercial market by enrollment.

13 (2) If the essential health benefits benchmark plan does not
14 include all of the ten benefit categories specified by section 1302 of
15 P.L. 111-148, as amended, the commissioner, in consultation with the
16 board and the health care authority, shall, by rule, supplement the
17 benchmark plan benefits as needed to meet the requirements of section
18 1302.

19 (3) A health plan required to offer the essential health benefits
20 under P.L. 111-148 of 2010, as amended, may not be offered in the state
21 unless the commissioner finds that it is substantially equal to the
22 benchmark plan. When making this determination, the commissioner must
23 ensure that the plan:

24 (a) Covers the ten essential health benefits categories specified
25 in section 1302 of P.L. 111-148 of 2010, as amended;

26 (b) Does not create a significant risk of biased selection based on
27 health status; and

28 (c) Contains meaningful benefits in each of the ten essential
29 health benefits categories specified by section 1302 of P.L. 111-148 of
30 2010, as amended.

31 (4) The commissioner must evaluate plans offered at each actuarial
32 value defined under section 1302 of P.L. 111-148, as amended, and
33 determine whether variation in prescription drug benefits, including
34 cost sharing, both inside and outside the exchange individual and small
35 group markets, results in adverse selection. If so, the commissioner
36 may adopt rules pursuant to chapter 34.05 RCW to assure substantial
37 equivalence of prescription drug benefits.

1 (5) In finalizing the decision for the benchmark plan and essential
2 health benefits, the commissioner must ensure a transparent, public
3 process that involves sharing information and allows public comment and
4 testimony.

5 **PART VI**
6 **THE BASIC HEALTH OPTION**

7 NEW SECTION. **Sec. 14.** A new section is added to chapter 70.47 RCW
8 to read as follows:

9 (1) The director of the health care authority shall provide the
10 necessary certifications to the secretary of the federal department of
11 health and human services under section 1331 of P.L. 111-148 of 2010,
12 as amended, for the purposes of Washington state's adoption of the
13 federal basic health program option, unless, by July 1, 2013, the
14 governor finds that:

15 (a) Anticipated federal funding under section 1331 will be
16 insufficient, absent any additional funding from the state, to provide
17 at least the essential health benefits to eligible individuals under
18 section 1331 during the period of calendar years 2014 through 2019:

19 (i) At enrollee premium levels below the levels that would be
20 applicable to persons with income between one hundred thirty-four and
21 two hundred percent of the federal poverty level through the Washington
22 health benefits exchange;

23 (ii) Using health plan payment rates sufficient to ensure access to
24 care for enrollees and incentivize an adequate provider network, in
25 conjunction with innovative payment methodologies and standard health
26 plan performance measures that will create incentives for the use of
27 effective cost containment and health care quality strategies; and

28 (iii) Assuming reasonable basic health program administrative costs
29 and the potential impact of federal basic health plan program funding
30 reconciliation under section 1331(d) of the affordable care act; and

31 (b) Sufficient funds are available to support the design and
32 development work necessary for the program to begin providing health
33 coverage to enrollees beginning January 1, 2014.

34 (2) Prior to making this finding, the director shall:

35 (a) Actively consult with the board of the Washington health

1 benefit exchange, the office of the insurance commissioner, consumer
2 advocates, provider organizations, carriers, and other interested
3 organizations;

4 (b) Consider any available objective analysis specific to
5 Washington state, by an independent nationally recognized consultant
6 that has been actively engaged in analysis and economic modeling of the
7 federal basic health program option for multiple states.

8 (3) The director shall report any findings and supporting analysis
9 made under this section to the relevant policy and fiscal committees of
10 the legislature.

11 (4) If implemented, the federal basic health program must be guided
12 by the following principles:

13 (a) Meeting the minimum state certification standards in section
14 1331 of the federal patient protection and affordable care act;

15 (b) To the extent allowed by the federal department of health and
16 human services, twelve-month continuous eligibility for the basic
17 health program, and corresponding twelve-month continuous enrollment in
18 standard health plans by enrollees; or, in lieu of twelve-month
19 continuous eligibility, financing mechanisms that enable enrollees to
20 remain with a plan for the entire plan year;

21 (c) Achieving an appropriate balance between:

22 (i) Premiums and cost-sharing minimized to increase the
23 affordability of insurance coverage;

24 (ii) Standard health plan contracting requirements that minimize
25 plan and provider administrative costs, while holding standard health
26 plans accountable for performance and enrollee health outcomes, and
27 ensuring adequate enrollee notice and appeal rights; and

28 (iii) Health plan payment rates that are sufficient to ensure
29 access to care for enrollees and incentivize an adequate provider
30 network, in conjunction with innovative payment methodologies and
31 standard health plan performance measures that will create incentives
32 for the use of effective cost containment and health care quality; and

33 (d) Transparency in program administration, including active and
34 ongoing consultation with basic health program enrollees and interested
35 organizations.

36 **PART VII**

1 **REINSURANCE**

2 **NEW SECTION. Sec. 15.** A new section is added to chapter 48.43 RCW
3 to read as follows:

4 (1) The commissioner, in consultation with the board, shall adopt
5 rules establishing the reinsurance program required by P.L. 111-148 of
6 2010, as amended. Consistent with federal law, the rules must, at a
7 minimum, establish:

8 (a) A mechanism to collect reinsurance contribution funds;

9 (b) A reinsurance payment formula; and

10 (c) A mechanism to disburse reinsurance payments.

11 (2)(a) The rules must compensate carriers offering health plans in
12 the exchange for the possibility of increased risk in the exchange and
13 incentivize carrier participation in the exchange by making any or all
14 of the following modifications to the reinsurance payment formula
15 established by federal law:

16 (i) Establishing a lower attachment point inside the exchange than
17 outside the exchange;

18 (ii) Establishing a higher reinsurance cap inside the exchange than
19 outside the exchange or eliminating the reinsurance cap inside the
20 exchange; or

21 (iii) Establishing a higher coinsurance rate inside the exchange
22 than outside the exchange.

23 (b) The commissioner may adjust the rules adopted under this
24 subsection (2) as needed to preserve a healthy market both inside and
25 outside of the exchange.

26 (c) The commissioner must identify by rule the data needed to
27 support operation of the reinsurance program established under this
28 section, the sources of the data, and other requirements related to its
29 collection, validation, interpretation, and retention.

30 (3) The rules adopted by the commissioner under this section may
31 not designate the reinsurance entity, unless the commissioner is
32 specifically authorized to do so by statute.

33 **PART VIII**

34 **THE WASHINGTON STATE HEALTH INSURANCE POOL**

35 **Sec. 16.** RCW 48.41.060 and 2011 c 314 s 13 are each amended to
36 read as follows:

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

6 ~~(a) ((Designate or establish the standard health questionnaire to
7 be used under RCW 48.41.100 and 48.43.018, including the form and
8 content of the standard health questionnaire and the method of its
9 application. The questionnaire must provide for an objective
10 evaluation of an individual's health status by assigning a discreet
11 measure, such as a system of point scoring to each individual. The
12 questionnaire must not contain any questions related to pregnancy, and
13 pregnancy shall not be a basis for coverage by the pool. The
14 questionnaire shall be designed such that it is reasonably expected to
15 identify the eight percent of persons who are the most costly to treat
16 who are under individual coverage in health benefit plans, as defined
17 in RCW 48.43.005, in Washington state or are covered by the pool, if
18 applied to all such persons;~~

19 ~~(b) Obtain from a member of the American academy of actuaries, who
20 is independent of the board, a certification that the standard health
21 questionnaire meets the requirements of (a) of this subsection;~~

22 ~~(c) Approve the standard health questionnaire and any modifications
23 needed to comply with this chapter. The standard health questionnaire
24 shall be submitted to an actuary for certification, modified as
25 necessary, and approved at least every thirty six months unless at the
26 time when certification is required the pool will be discontinued
27 before the end of the succeeding thirty six month period. The
28 designation and approval of the standard health questionnaire by the
29 board shall not be subject to review and approval by the commissioner.
30 The standard health questionnaire or any modification thereto shall not
31 be used until ninety days after public notice of the approval of the
32 questionnaire or any modification thereto, except that the initial
33 standard health questionnaire approved for use by the board after March
34 23, 2000, may be used immediately following public notice of such
35 approval;~~

36 ~~(d)) Establish appropriate rates, rate schedules, rate
37 adjustments, expense allowances, claim reserve formulas and any other
38 actuarial functions appropriate to the operation of the pool. Rates~~

1 shall not be unreasonable in relation to the coverage provided, the
2 risk experience, and expenses of providing the coverage. Rates and
3 rate schedules may be adjusted for appropriate risk factors such as age
4 and area variation in claim costs and shall take into consideration
5 appropriate risk factors in accordance with established actuarial
6 underwriting practices consistent with Washington state individual plan
7 rating requirements under RCW 48.44.022 and 48.46.064;

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

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

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

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

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

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

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

7 ~~(j))~~ (d) Provide certification to the commissioner when
8 assessments will exceed the threshold level established in RCW
9 48.41.037.

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

11 (a) Enter into contracts as are necessary or proper to carry out
12 the provisions and purposes of this chapter including the authority,
13 with the approval of the commissioner, to enter into contracts with
14 similar pools of other states for the joint performance of common
15 administrative functions, or with persons or other organizations for
16 the performance of administrative functions;

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

20 (c) Appoint appropriate legal, actuarial, and other committees as
21 necessary to provide technical assistance in the operation of the pool,
22 policy, and other contract design, and any other function within the
23 authority of the pool; and

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

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

30 **Sec. 17.** RCW 48.41.110 and 2011 c 315 s 6 are each amended to read
31 as follows:

32 (1) The pool shall offer one or more care management plans of
33 coverage. Such plans may, but are not required to, include point of
34 service features that permit participants to receive in-network
35 benefits or out-of-network benefits subject to differential cost
36 shares. The pool may incorporate managed care features into existing
37 plans.

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

5 (3) The health insurance policies issued by the pool shall pay only
6 reasonable amounts for medically necessary eligible health care
7 services rendered or furnished for the diagnosis or treatment of
8 covered illnesses, injuries, and conditions. Eligible expenses are the
9 reasonable amounts for the health care services and items for which
10 benefits are extended under a pool policy.

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

14 (a) Hospital services, including charges for the most common
15 semiprivate room, for the most common private room if semiprivate rooms
16 do not exist in the health care facility, or for the private room if
17 medically necessary, including no less than a total of one hundred
18 eighty inpatient days in a calendar year, and no less than thirty days
19 inpatient care for alcohol, drug, or chemical dependency or abuse per
20 calendar year;

21 (b) Professional services including surgery for the treatment of
22 injuries, illnesses, or conditions, other than dental, which are
23 rendered by a health care provider, or at the direction of a health
24 care provider, by a staff of registered or licensed practical nurses,
25 or other health care providers;

26 (c) No less than twenty outpatient professional visits for the
27 diagnosis or treatment of alcohol, drug, or chemical dependency or
28 abuse rendered during a calendar year by a state-certified chemical
29 dependency program approved under chapter 70.96A RCW, or by one or more
30 physicians, psychologists, or community mental health professionals,
31 or, at the direction of a physician, by other qualified licensed health
32 care practitioners;

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

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

37 (f) Services of a home health agency;

1 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
2 therapy;

3 (h) Oxygen;

4 (i) Anesthesia services;

5 (j) Prostheses, other than dental;

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

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

9 (m) Oral surgery including at least the following: Fractures of
10 facial bones; excisions of mandibular joints, lesions of the mouth,
11 lip, or tongue, tumors, or cysts excluding treatment for
12 temporomandibular joints; incision of accessory sinuses, mouth salivary
13 glands or ducts; dislocations of the jaw; plastic reconstruction or
14 repair of traumatic injuries occurring while covered under the pool;
15 and excision of impacted wisdom teeth;

16 (n) Maternity care services;

17 (o) Services of a physical therapist and services of a speech
18 therapist;

19 (p) Hospice services;

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

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

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

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

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

37 (7)(a) The pool may not reject an individual for health plan
38 coverage based upon preexisting conditions of the individual or deny,

1 exclude, or otherwise limit coverage for an individual's preexisting
2 health conditions; except that it shall impose a six-month benefit
3 waiting period for preexisting conditions for which medical advice was
4 given, for which a health care provider recommended or provided
5 treatment, or for which a prudent layperson would have sought advice or
6 treatment, within six months before the effective date of coverage.
7 The preexisting condition waiting period shall not apply to prenatal
8 care services or extend beyond December 31, 2013. The pool may not
9 avoid the requirements of this section through the creation of a new
10 rate classification or the modification of an existing rate
11 classification. Credit against the waiting period shall be as provided
12 in subsection (8) of this section.

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

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

29 (b) The pool shall waive any preexisting condition waiting period
30 for a person who is an eligible individual as defined in section
31 2741(b) of the federal health insurance portability and accountability
32 act of 1996 (42 U.S.C. 300gg-41(b)).

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

37 (10) The pool shall contract with organizations that provide care
38 management that has been demonstrated to be effective and shall

1 encourage enrollees who are eligible for care management services to
2 participate. The pool may encourage the use of shared decision making
3 and certified decision aids for preference-sensitive care areas.

4 **Sec. 18.** RCW 48.41.170 and 1987 c 431 s 17 are each amended to
5 read as follows:

6 The commissioner shall adopt rules pursuant to chapter 34.05 RCW
7 that((÷

8 ~~(1) Provide for disclosure by the member of the availability of~~
9 ~~insurance coverage from the pool; and~~

10 ~~(2))~~ implement this chapter.

11 NEW SECTION. **Sec. 19.** A new section is added to chapter 48.41 RCW
12 to read as follows:

13 For policies renewed beginning January 1, 2014:

14 (1) Rates for pool coverage may be no more than the average
15 individual standard rate charged for coverage comparable to pool
16 coverage by the five largest members, measured in terms of individual
17 market enrollment, offering such coverages in the state. In the event
18 five members do not offer comparable coverage, rates for pool coverage
19 may be no more than the standard risk rate established using reasonable
20 actuarial techniques and must reflect anticipated experience and
21 expenses for such coverage in the individual market.

22 (2)(a) The pool shall reduce an enrollee's premium obligation as
23 needed to provide the enrollee with premium subsidies equivalent to
24 what he or she would have received in the exchange if the enrollee:

25 (i) Has a modified adjusted gross income below four hundred percent
26 of federal poverty level;

27 (ii) Is not enrolled in medicare; and

28 (iii) Does not have an offer of minimum essential coverage.

29 (b) Premium subsidies provided under this subsection shall be
30 funded through member assessments.

31 NEW SECTION. **Sec. 20.** A new section is added to chapter 48.41 RCW
32 to read as follows:

33 (1) Only persons enrolled in a health benefit plan through the pool
34 on December 31, 2013, who do not disenroll after December 31, 2013, are
35 eligible for pool coverage.

1 (2) The board shall evaluate the populations that may need ongoing
2 access to the pool coverage paying particular attention to those that
3 may be excluded from coverage in 2014, and submit recommendations to
4 the legislature by December 1, 2012, on any modifications to the pool
5 eligibility for new enrollees after January 1, 2014.

6 (3) The board shall complete an analysis of the pool assessments in
7 relation to the assessments for the reinsurance program established in
8 section 15 of this act and the risk management functions in section 21
9 of this act. The board shall forward recommendations to the
10 legislature with suggested changes for the assessment or any credits
11 that may be considered for the reinsurance program.

12 NEW SECTION. **Sec. 21.** A new section is added to chapter 48.41 RCW
13 to read as follows:

14 (1) The pool may perform all or part of the risk management
15 functions in the federal patient protection and affordable care act if
16 authorized by statute.

17 (2) To further timely state implementation of the federal patient
18 protection and affordable care act in the state, the pool is authorized
19 to conduct preoperational and planning activities related to these
20 programs, including defining and implementing an appropriate legal
21 structure or structures to administer and coordinate these programs.

22 (3) Funding for the transitional reinsurance program as provided by
23 assessments pursuant to section 1341 of the federal patient protection
24 and affordable care act may be increased in this state by inclusion of
25 additional assessment amounts to cover the administrative costs of
26 operation of the reinsurance program including reimbursement of the
27 reasonable costs incurred by the pool for preoperational activities
28 undertaken pursuant to this section.

29 (4) The pool shall report on these activities to the appropriate
30 committees of the senate and house of representatives by December 15,
31 2012, and December 15, 2013.

32 NEW SECTION. **Sec. 22.** The following acts or parts of acts, as now
33 existing or hereafter amended, are each repealed, effective January 1,
34 2014:

35 (1) RCW 48.43.018 (Requirement to complete the standard health
36 questionnaire--Exemptions--Results) and 2010 c 277 s 1 & 2009 c 42 s 1;

1 (2) RCW 48.41.020 (Intent) and 2000 c 79 s 5 & 1987 c 431 s 2;
2 (3) RCW 48.41.100 (Eligibility for coverage) and 2011 c 315 s 5,
3 2011 c 314 s 15, 2009 c 555 s 3, 2007 c 259 s 30, 2001 c 196 s 3, 2000
4 c 79 s 12, 1995 c 34 s 5, 1989 c 121 s 7, & 1987 c 431 s 10; and
5 (4) RCW 48.41.200 (Rates--Standard risk and maximum) and 2007 c 259
6 s 28, 2000 c 79 s 17, 1997 c 231 s 214, & 1987 c 431 s 20.

7 **PART IX**
8 **MISCELLANEOUS**

9 NEW SECTION. **Sec. 23.** If any provision of this act or its
10 application to any person or circumstance is held invalid, the
11 remainder of the act or the application of the provision to other
12 persons or circumstances is not affected.

13 NEW SECTION. **Sec. 24.** Sections 16, 18, and 20 of this act take
14 effect January 1, 2014.

15 NEW SECTION. **Sec. 25.** Sections 4 and 5 of this act are necessary
16 for the immediate preservation of the public peace, health, or safety,
17 or support of the state government and its existing public
18 institutions, and take effect immediately.

--- END ---