Z-0672.1

HOUSE BILL 2121

State of Washington 61st Legislature 2009 Regular Session

By Representatives Morrell, Green, Hunt, Hudgins, Kenney, Darneille, Miloscia, Liias, Simpson, Hasegawa, McCoy, Goodman, Williams, Chase, Nelson, Conway, and Ormsby; by request of Insurance Commissioner

Read first time 02/10/09. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to providing preventive and catastrophic health
2 coverage through a guaranteed health benefit program for permanent
3 residents of this state; amending RCW 48.14.020, 48.02.190, and
4 70.47.020; reenacting and amending RCW 48.14.0201 and 43.79A.040;
5 adding a new section to chapter 42.56 RCW; adding a new chapter to
6 Title 70 RCW; and providing for submission of this act to a vote of the
7 people.

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

9 NEW SECTION. **Sec. 1.** It is the intent of the legislature to
10 protect residents of this state from catastrophic health costs and
11 ensure access to meaningful preventive health care. The program
12 established by this chapter provides care to all residents of this
13 state not enrolled in both parts A and B of medicare, veterans'
14 benefits, TRICARE, CHAMPUS, FEHBP, or other federal or state government
15 programs, or who are confined or reside in a government-operated
16 institution.
17 The legislature finds that such a program will help ensure the
18 financial security of all residents of this state by providing broad
19 pooling of catastrophic health care costs.

1 The legislature finds that lack of preventive and catastrophic
2 coverage can adversely affect the health of residents of Washington.
3 The legislature further finds that a significant percentage of the
4 population of this state does not have reasonably available insurance
5 or other coverage for the costs of necessary preventive and
6 catastrophic health care. This lack of health care is detrimental to
7 the health of individuals lacking coverage and to the public welfare,
8 and results in substantial expenditures for emergency and remedial
9 health care, often at the expense of health care providers, health care
10 facilities, and all purchasers of health care, including the state.

11 NEW SECTION. **Sec. 2.** The definitions in this section apply
12 throughout this chapter unless the context clearly requires otherwise.
13 (1) "Allowed charges" means those expenses incurred by covered
14 persons for medically necessary expenses based on the terms and
15 conditions of the program, as defined by the board.
16 (2) "Authority" means the state health care authority established
17 in chapter 41.05 RCW.
18 (3) "Board" means the guaranteed health benefits board created in
19 section 7 of this act.
20 (4) "Carrier" or "participating carrier" means a disability
21 insurance company regulated under chapter 48.20 or 48.21 RCW, a health
22 care service contractor as defined in RCW 48.44.010, and a health
23 maintenance organization as defined in RCW 48.46.020. Carrier also
24 includes any self-funded program that may be created by the authority
25 under this chapter and any entity that offers to participate in the
26 program even if that entity is not otherwise subject to regulation
27 under Title 48 RCW.
28 (5) "CHAMPUS" means the civilian health and medical program of the
29 uniformed services.
30 (6) "Code" means the internal revenue code, as codified in Title 26
31 U.S.C., as amended.
32 (7) "Commissioner" means the Washington state insurance
33 commissioner or the commissioner's designee.
34 (8) "Competitive bid process" means a documented formal process
35 providing an equal and open opportunity to qualified carriers and
36 culminating in a selection based on criteria that may include such
37 factors as the carrier's fees or costs, ability, capacity, experience,

reputation, responsiveness to time limitations, responsiveness to solicitation requirements, quality of previous performance, or compliance with statutes and rules relating to contracts or services.

(9) "Coverage year" means a calendar year, unless the authority adopts a different twelve-month period.

(10) "Creditable coverage" means the period an individual was covered under a group or individual health plan or insurance in another state or through an otherwise excluded plan of health care coverage that provided benefits similar to or more comprehensive than those offered by the program for at least three months without a break in coverage of more than sixty-three days.

(11) "Employee" includes common law employees and leased employees of an employer.

(12) "Employer" or "business entity" means any business having employees that are permanent residents of this state who are subject to medicare tax. Employer includes all of the following forms of business: Partnerships, subchapter "c" and "s" corporations, nonprofit organizations, governmental entities, limited liability corporations or partnerships, and sole proprietorships.

(13) "FEHBP" means the federal employees health benefits program.

(14) "Medical assistance" or "medicaid" means coverage under Title XIX of the federal social security act (42 U.S.C. Sec. 1396 et seq., as amended) and chapter 74.09 RCW.

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

(16) "Permanent residence" means the place where a person lives with the intent to make it a fixed and permanent home. For purposes of this chapter, it has the same meaning as "domicile."

(17) "Permanent resident" means a person who permanently resides in Washington. Persons with homes in more than one state are considered permanent residents of this state if they intend to make Washington their permanent home and reside in this state for at least six months each year. A person is not a permanent resident if he or she remains away from this state for more than six consecutive months and does not intend to make Washington his or her permanent home.

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

(19) "Program" means the guaranteed health benefit program created in this chapter.

(20) "Resident" means a person living in a particular locality in the state of Washington. Confinement of a person in a nursing home, hospital, or other institution by itself is not sufficient to qualify a person as a resident.

(21) "Routine coverage" means coverage for incurred health care costs, other than the preventive services offered by the program, up to the annual threshold.

(22) "Secretary" means the secretary of the department of social and health services or the secretary's designee.

(23) "Wellness program" or "wellness activity" means a bona fide, explicit program of an activity, such as but not limited to smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, or nutrition education for the purpose of improving enrollee health status and reducing health service costs.

NEW SECTION. **Sec. 3.** The guaranteed health benefit program is created.

(1) On the effective date of this section, and except as set forth in this section, every person who has permanently resided in Washington state for at least six months, and all children born in this state on or after the effective date of this section who live with an eligible resident parent or legal guardian, are enrolled in the program.

(2)(a) Persons moving to this state after the effective date of this section who provide satisfactory evidence of permanent residency in this state to the authority must be enrolled into the program.

(b) Any person moving to this state after the effective date of this section who cannot provide evidence of creditable coverage is eligible for the program, upon satisfactory evidence of permanent residency, after six months of permanent residency. However, no preexisting condition will be covered until the person has permanently resided in Washington for twelve months.

(3) Persons not eligible for the program include persons who are:

(a) Enrolled in both parts A and B of medicare;

1 (b) Enrolled in federal government programs such as but not limited
2 to medicare, veterans' administration benefits, TRICARE, CHAMPUS, and
3 FEHBP;
4 (c) Eligible for entitlement programs, such as medicaid, identified
5 as providing substantially similar or more comprehensive coverage by
6 the board, after consultation with the secretary, governed by chapter
7 74.09 RCW or chapters 388-500 through 388-561 WAC; or
8 (d) Confined or reside in a government-operated institution.
9 (4) The board shall consider whether to allow participation
10 waivers. For example, the board may allow employers with self-funded
11 health care programs to waive participation in the program for that
12 employer's employees, and the terms of any such waiver.
13 (5) Persons who disenroll from federal health care programs or who
14 cease to reside in a government-operated institution must be registered
15 with a participating carrier based on rules adopted by the authority.
16 (6) Each person must be covered as an individual.
17 (7) Coverage continues in force as long as the person permanently
18 resides in this state.
19 (8) Participating carriers shall accept every eligible person
20 immediately upon receipt of a completed registration form, subject to
21 reasonable verification of eligibility, as established by the authority
22 by rule.
23 (9) The authority shall adopt standards for implementing this
24 section by rule, including evidence of permanent residency and
25 creditable coverage and procedures for registering with participating
26 carriers.

27 NEW SECTION. **Sec. 4.** (1) Except as provided in this section, all
28 participating carriers must accept any eligible person that registers
29 for coverage with the carrier as long as the person resides in the area
30 in which the carrier is contracted to offer coverage.
31 (2) If a person chooses a different carrier during an open
32 enrollment period for the following coverage year, the prior carrier
33 must cooperate with the new carrier and the eligible person during
34 transition of coverage.
35 (3) Upon request of a covered person during an open enrollment
36 period, a participating carrier must continue coverage for a covered
37 person:

(a) Unless the covered person commits a fraud against the program or the carrier;

(b) Unless the covered person no longer resides in the participating carrier's contracted area;

(c) Unless the covered person is no longer eligible to participate in the program, such as if the person establishes permanent residency in another state; or

(d) For other conditions as the authority may adopt by rule.

NEW SECTION. **Sec. 5.** (1) With respect to coverage for persons eligible for the program on the effective date of this section and who become eligible thereafter, there is no limitation or exclusion of benefits relating to a preexisting condition because the condition was present or expected before the date of eligibility for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(2) Benefits for persons moving to Washington after the effective date of this section may not be excluded or limited for any preexisting condition that occurred more than twelve months prior to the date the person first establishes permanent residency in this state.

NEW SECTION. **Sec. 6.** The program shall be funded as directed by the legislature.

NEW SECTION. **Sec. 7.** The guaranteed health benefits board is established to govern the program as set forth in this section.

(1) The governor shall appoint nine members to the board who shall represent: The general public; health care providers, including health care facilities; carriers; business, both large and small business entities; and labor. The administrator of the authority is the chair of the board.

(2)(a) The original members of the board must be appointed for intervals of one to three years. Thereafter, all board members serve a term of three years.

(b) Appointed members of the board are eligible for reappointment.

(c) Board members serve without compensation, except that they may be reimbursed for travel expenses pursuant to RCW 43.03.050 and 43.03.060.

(d) The board shall adopt a plan of operation, bylaws, and other governing documents as may be necessary to ensure the fair, reasonable, and equitable operation of the board.

(e) Meetings of the board are subject to the open public meetings act, chapter 42.30 RCW.

NEW SECTION. **Sec. 8.** The board shall determine the schedule of benefits for the program and establish a schedule of allowed charges for any self-funded arrangement, including a list of expenses that are covered or excluded under the program.

(1) Scheduled benefits for preventive care must include annual examinations, cancer screenings, immunizations, and other benefits the board determines to cover, taking into account recommendations of the United States preventive services task force. Based on an evaluation of efficacy and cost, the board shall periodically consider the suitability of adding one or more annual preventive dental care visits.

(2) Catastrophic coverage must include coverage for medically necessary care after a covered person incurs allowed charges, as determined by the board, in excess of ten thousand dollars during a coverage year.

(a) The board shall annually consider the desirability and necessity of increasing the catastrophic benefits trigger point based on inflation or other factors.

(b) The authority shall adopt any increase in the catastrophic benefits trigger point by rule at the direction of the board.

(3) Mandated benefits, services, included providers, and patient bill of rights protections. The schedule of benefits adopted by the board must include all mandated benefits and mandated offerings in force as of the effective date of this section, as well as all state statutes and rules regarding patient rights and carrier contracting with categories of providers, including the state's grievance and appeals requirements and a person's right to request an independent review of medical necessity decisions made by a carrier, as provided in RCW 43.70.235, 48.43.500 through 48.43.535, 48.43.545, 48.43.550, 70.02.045, 70.02.110, and 70.02.900.

(4) Participation of persons eligible for substantially similar or more comprehensive state-funded programs governed by chapter 74.09 RCW or chapters 388-500 through 388-561 WAC must be jointly reviewed by the

administrator and the secretary. Persons eligible for such programs may not receive duplicate coverage and benefits must be coordinated among state or federal payers and the program.

(5) The board may establish criteria and procedures for a self-funded employer to waive participation in the program, in whole or in part.

NEW SECTION. **Sec. 9.** (1) The board may negotiate with Indian tribes for inclusion in the program of any or all of the following:

(a) Tribal members employed on tribal lands by tribal-owned and operated employers;

(b) Tribal members employed by nontribal employers on and off tribal lands; or

(c) Nontribal employers employing tribal members on and off tribal lands.

(2) The board shall consider or authorize the authority or a contracted entity to consider the desirability, costs, and feasibility of developing a component or subpart of the program that is compatible with a health savings account, health reimbursement account, or other similar federally tax-qualified health care plan. If the board determines that such a program component or subpart is desirable, cost-effective, feasible, and consistent with the goals of the program, the board shall direct the authority to implement the board's conclusions.

NEW SECTION. **Sec. 10.** (1) Expenses allowed for purposes of determining eligibility for catastrophic benefits must fall within the allowable incurred expense schedule established by the board, must not be otherwise excluded from coverage, must have been incurred by and for the enrollee claiming the expense, must have been incurred during the plan year for which the expense is presented, must fall within any limits set by the board for medical expenses, and must be primarily for a medical purpose.

(2) The board shall establish criteria for the authority's use in determining eligibility of incurred medical expenses.

(a) The board may adopt a schedule of allowable incurred expenses to determine eligibility based on section 213(d) of the federal internal revenue code, or any other generally recognized, appropriate criteria.

(b) The board shall instruct the authority to adopt by rule any appropriate exceptions to qualifying expenses determined by the board to be necessary or appropriate. For example, exclusions or exceptions to allowable incurred expenses may include, but need not be limited to the following: Over-the-counter drugs, fertility treatments, or cosmetic procedures (except those necessary to ameliorate a deformity arising from a congenital abnormality or personal injury from accident or trauma or disfiguring disease).

(c) Evidence of any expense incurred must be capable of corroboration by an independent third party and must include all of the following: A description of the service or product, the date of the service or sale, and the amount of the expense. For example, such evidence of an expense could be a receipt or billing from the provider or seller.

(3) For purposes of this section, "medical care" or "medical purpose" means costs that were incurred by the enrollee for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.

NEW SECTION. **Sec. 11.** The authority shall administer, supervise, and manage the program.

(1) The authority shall adopt administrative cost savings plans and incentives designed to reduce the administrative burdens of carriers, providers, and the program.

(2) The authority shall adopt rules for contracting with participating carriers that:

(a) Rewards health outcomes rather than simply paying for particular procedures;

(b) Pays for health care that reflects patient preference and is of proven value; and

(c) Calls for the use of evidence-based standards of care where available.

(3) The authority may appoint such technical or advisory committees as are deemed necessary or desirable by the board or the authority. Members shall serve without compensation for their services but may be reimbursed for their travel expenses, as provided in RCW 43.03.050 and 43.03.060.

(4) The authority may adopt rules to administer the program, including but not limited to rules that establish procedures for appeals of eligibility decisions, establish appeals procedures for enforcement actions and other purposes the authority determines are necessary for the efficient and effective administration of the program, and ensure that all covered persons receive quality health care and that all covered services are medically necessary and efficacious, cost-effective, and reasonable in relation to the services delivered.

(5) The authority may appoint a medical director and other staff the authority determines are necessary or appropriate to fulfill the responsibilities and duties necessary for the administration of the program.

(6)(a) The authority may contract with private entities or enter into interagency agreements with public agencies to provide technical or professional assistance or assist in the administration of the program.

(b) Any such contractor is prohibited from releasing, publishing, or otherwise using any information made available to it under its contractual responsibility without specific permission of the authority.

(7) The authority may apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person and may make arrangements for the use of these receipts, including the undertaking of special studies and other projects relating to health care costs or access to health care.

(8) The authority shall develop and implement a plan to publicize the existence of the program and maintain public awareness of the program and shall publicize open enrollment options for eligible persons.

(9) The authority shall review all publications of carriers related to the program for compliance with applicable state and federal requirements.

(10) The authority shall periodically report to the board on all operations of the program, prepare an annual budget, and manage the administrative expenses of the program.

1 (11) The board shall report to the legislature on all operations of
2 the program every two years, in odd-numbered years.

3 NEW SECTION. **Sec. 12.** By July 1, 2010, or at a later date as the
4 board may determine, the authority shall establish a program for
5 accepting enrollment registration forms for receipt of services from
6 participating carriers, with the intent that the first coverage year
7 begin January 1, 2011, or at a later date as the board may determine.
8 (1) Eligible persons must register with the same participating
9 carrier for guaranteed health coverage and routine coverage.
10 (2) Eligible persons who do not register with a carrier before the
11 first day of a coverage year must be assigned to a participating
12 carrier through a rotational system to be established and managed by
13 the authority.
14 (3) Registration with a participating carrier must be for the
15 entire coverage year except as may be established by the authority by
16 rule.
17 (4) Parents or legal guardians may register their dependents.
18 (5) Students attending school in another state may continue program
19 coverage under rules adopted by the authority.
20 (6) Eligibility for the program ceases the first day of the month
21 following establishment of permanent residency in another state.

22 NEW SECTION. **Sec. 13.** Benefits must be provided by carriers
23 selected by the authority after completion of a competitive bid process
24 through one or more contracts with carriers.
25 (1)(a) The authority shall issue a request for proposals, including
26 standards regarding the quality of services to be provided; financial
27 integrity of the responding carriers; and responsiveness to the unmet
28 health care needs of the local communities or populations that may be
29 served;
30 (b) The authority shall review responsive proposals and may
31 negotiate with bidders to the extent necessary to refine any proposals;
32 and
33 (c) The authority may contract with one or more carriers to provide
34 the covered services within a local area.
35 (2) All participating contracted carriers must be in good standing
36 with the office of insurance commissioner.

(3) The rates charged by carriers must be negotiated by the authority and approved by the board. Rates may not change more frequently than annually.

(4) Payment to participating contracted carriers must be by a capitated arrangement.

NEW SECTION. **Sec. 14.** In order to ensure availability of program coverage throughout the entire state and choice for program enrollees, one or more self-funded arrangements may be offered in areas of the state if the authority determines that fewer than two options for enrollment will be available to eligible enrollees in any coverage year.

NEW SECTION. **Sec. 15.** Rates for program benefits shall be based on actuarially sound rating principles. Rates paid to participating carriers, including any self-funded arrangement, must be risk adjusted annually based on experience during the most recent prior year for which statistics related to rates and risk are available and applied to the rates charged by a participating carrier for the next succeeding coverage year.

(1) Every carrier that participates in the program must submit to the authority, or to a third party at the direction of the authority, all information deemed necessary for risk assessment and adjustment calculations, including demographic and claims data.

(2) Carriers that do not participate in the program in later years shall provide all necessary data to the authority, or to a third party at the direction of the authority, for the carrier's years of participation in the program.

(3) The authority shall implement a self-administered method of providing coverage to enrollees if the authority determines that no carrier is willing and able to provide access to covered services for all enrollees in an area of the state.

(4) All claims data related to the program are the property of the state.

(5) The authority shall adopt rules to establish and manage risk adjustment.

NEW SECTION. **Sec. 16.** (1) The authority shall conduct an annual open enrollment period for the program of no fewer than thirty days each twelve-month period during which any person may choose to change participating carriers for the following coverage year.

(2) The authority shall establish by rule standards by which a person may change participating carriers at times other than during the annual open enrollment period.

(a) A person may not be registered with more than one participating carrier at the same time.

(b) When changing carriers, there must be no overlap and no gap in an enrollee's coverage.

NEW SECTION. **Sec. 17.** It is the express intent of this chapter that the program be secondary to all amounts paid or payable through any worker's compensation coverage, automobile medical payment, or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any federal law or program.

NEW SECTION. **Sec. 18.** Participating carriers shall file reports with the authority in a format, manner, and time designated by the authority by rule.

NEW SECTION. **Sec. 19.** The insurance commissioner has authority over the solvency of participating carriers.

NEW SECTION. **Sec. 20.** The privacy protections of chapters 48.43 and 70.02 RCW and the federal health insurance portability and accountability act (45 C.F.R. 160 et seq.) apply to all contracts issued to participating carriers and all actions of the board, the authority, the commissioner, and the secretary of the department of social and health services.

Sec. 21. RCW 48.14.020 and 2008 c 217 s 6 are each amended to read as follows:

(1) Subject to other provisions of this chapter, each authorized insurer except title insurers shall on or before the first day of March of each year pay to the state treasurer through the commissioner's

office a tax on premiums. Except as provided in subsection (2) of this section, such tax shall be in the amount of two percent of all premiums, excluding amounts returned to or the amount of reductions in premiums allowed to holders of industrial life policies for payment of premiums directly to an office of the insurer, collected or received by the insurer during the preceding calendar year other than ocean marine and foreign trade insurances, after deducting premiums paid to policyholders as returned premiums, upon risks or property resident, situated, or to be performed in this state. For the purposes of this section the consideration received by an insurer for the granting of an annuity shall not be deemed to be a premium. Moneys paid as the result of contracts issued to participating carriers for the purpose of providing health care coverage under the program created in chapter 70.-- RCW (the new chapter created in section 40 of this act) will be treated as premiums.

(2) In the case of insurers which require the payment by their policyholders at the inception of their policies of the entire premium thereon in the form of premiums or premium deposits which are the same in amount, based on the character of the risks, regardless of the length of term for which such policies are written, such tax shall be in the amount of two percent of the gross amount of such premiums and premium deposits upon policies on risks resident, located, or to be performed in this state, in force as of the thirty-first day of December next preceding, less the unused or unabsorbed portion of such premiums and premium deposits computed at the average rate thereof actually paid or credited to policyholders or applied in part payment of any renewal premiums or premium deposits on one-year policies expiring during such year.

(3) Each authorized insurer shall with respect to all ocean marine and foreign trade insurance contracts written within this state during the preceding calendar year, on or before the first day of March of each year pay to the state treasurer through the commissioner's office a tax of ninety-five one-hundredths of one percent on its gross underwriting profit. Such gross underwriting profit shall be ascertained by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance) on such ocean marine and foreign trade insurance contracts the net losses paid (i.e., gross losses paid less salvage and recoveries on reinsurance ceded)

1 during such calendar year under such contracts. In the case of
2 insurers issuing participating contracts, such gross underwriting
3 profit shall not include, for computation of the tax prescribed by this
4 subsection, the amounts refunded, or paid as participation dividends,
5 by such insurers to the holders of such contracts.

6 (4) The state does hereby preempt the field of imposing excise or
7 privilege taxes upon insurers or their appointed insurance producers,
8 other than title insurers, and no county, city, town or other municipal
9 subdivision shall have the right to impose any such taxes upon such
10 insurers or these insurance producers.

11 (5) If an authorized insurer collects or receives any such premiums
12 <u>or moneys for coverage under contracts issued on behalf of the program</u>
13 <u>created under chapter 70.-- RCW (the new chapter created in section 40</u>
14 <u>of this act)</u> on account of policies in force in this state which were
15 originally issued by another insurer and which other insurer is not
16 authorized to transact insurance in this state on its own account, such
17 collecting insurer shall be liable for and shall pay the tax on such
18 premiums.

19 **Sec. 22.** RCW 48.14.0201 and 2005 c 405 s 1, 2005 c 223 s 6, and
20 2005 c 7 s 1 are each reenacted and amended to read as follows:

21 (1) As used in this section, "taxpayer" means a health maintenance
22 organization as defined in RCW 48.46.020, a health care service
23 contractor as defined in RCW 48.44.010, or a self-funded multiple
24 employer welfare arrangement as defined in RCW 48.125.010.

25 (2) Each taxpayer shall pay a tax on or before the first day of
26 March of each year to the state treasurer through the insurance
27 commissioner's office. The tax shall be equal to the total amount of
28 all premiums and prepayments for health care services received by the
29 taxpayer during the preceding calendar year multiplied by the rate of
30 two percent. <u>For the purposes of this section, moneys paid as the</u>
31 <u>result of contracts issued to these taxpayers for the purpose of</u>
32 <u>providing health care coverage under the program created in chapter</u>
33 <u>70.-- RCW (the new chapter created in section 40 in this act) will be</u>
34 <u>treated as premiums.</u>

35 (3) Taxpayers shall prepay their tax obligations under this
36 section. The minimum amount of the prepayments shall be percentages of
37 the taxpayer's tax obligation for the preceding calendar year

recomputed using the rate in effect for the current year. For the prepayment of taxes due during the first calendar year, the minimum amount of the prepayments shall be percentages of the taxpayer's tax obligation that would have been due had the tax been in effect during the previous calendar year. The tax prepayments shall be paid to the state treasurer through the commissioner's office by the due dates and in the following amounts:

(a) On or before June 15, forty-five percent;

(b) On or before September 15, twenty-five percent;

(c) On or before December 15, twenty-five percent.

(4) For good cause demonstrated in writing, the commissioner may approve an amount smaller than the preceding calendar year's tax obligation as recomputed for calculating the health maintenance organization's, health care service contractor's, self-funded multiple employer welfare arrangement's, or certified health plan's prepayment obligations for the current tax year.

(5) Moneys collected under this section shall be deposited in the general fund through March 31, 1996, and in the health services account under RCW 43.72.900 after March 31, 1996.

(6) The taxes imposed in this section do not apply to:

(a) Amounts received by any taxpayer from the United States or any instrumentality thereof as prepayments for health care services provided under Title XVIII (medicare) of the federal social security act.

(b) Amounts received by any taxpayer from the state of Washington as prepayments for health care services provided under:

(i) The medical care services program as provided in RCW 74.09.035;

(ii) The Washington basic health plan on behalf of subsidized enrollees as provided in chapter 70.47 RCW; or

(iii) The medicaid program on behalf of elderly or disabled clients as provided in chapter 74.09 RCW when these prepayments are received prior to July 1, 2009, and are associated with a managed care contract program that has been implemented on a voluntary demonstration or pilot project basis.

(c) Amounts received by any health care service contractor, as defined in RCW 48.44.010, as prepayments for health care services included within the definition of practice of dentistry under RCW 18.32.020.

(d) Participant contributions to self-funded multiple employer welfare arrangements that are not taxable in this state.

(7) Beginning January 1, 2000, the state does hereby preempt the field of imposing excise or privilege taxes upon taxpayers and no county, city, town, or other municipal subdivision shall have the right to impose any such taxes upon such taxpayers. This subsection shall be limited to premiums and payments for health benefit plans offered by health care service contractors under chapter 48.44 RCW, health maintenance organizations under chapter 48.46 RCW, ((~~and~~)) self-funded multiple employer welfare arrangements as defined in RCW 48.125.010, and any moneys received for coverage under contracts issued on behalf of the program created in chapter 70.-- RCW (the new chapter created in section 40 of this act). The preemption authorized by this subsection shall not impair the ability of a county, city, town, or other municipal subdivision to impose excise or privilege taxes upon the health care services directly delivered by the employees of a health maintenance organization under chapter 48.46 RCW.

(8)(a) The taxes imposed by this section apply to a self-funded multiple employer welfare arrangement only in the event that they are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing state premium taxes on these arrangements. Once the legality of the taxes has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these taxes.

(b) If there has not been a final determination of the legality of these taxes, then beginning on the earlier of (i) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (ii) April 1, 2006, the arrangement shall deposit the taxes imposed by this section into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the taxes are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the state treasurer.

(9) The effect of transferring contracts for health care services from one taxpayer to another taxpayer is to transfer the tax prepayment obligation with respect to the contracts.

(10) On or before June 1st of each year, the commissioner shall notify each taxpayer required to make prepayments in that year of the amount of each prepayment and shall provide remittance forms to be used by the taxpayer. However, a taxpayer's responsibility to make prepayments is not affected by failure of the commissioner to send, or the taxpayer to receive, the notice or forms.

Sec. 23. RCW 48.02.190 and 2008 c 328 s 6003 are each amended to read as follows:

(1) As used in this section:

(a) "Organization" means every insurer, as defined in RCW 48.01.050, having a certificate of authority to do business in this state, every health care service contractor, as defined in RCW 48.44.010, every health maintenance organization, as defined in RCW 48.46.020, or self-funded multiple employer welfare arrangement, as defined in RCW 48.125.010, registered to do business in this state. "Class one" organizations shall consist of all insurers as defined in RCW 48.01.050. "Class two" organizations shall consist of all organizations registered under provisions of chapters 48.44 and 48.46 RCW. "Class three" organizations shall consist of self-funded multiple employer welfare arrangements as defined in RCW 48.125.010.

(b)(i) "Receipts" means (A) net direct premiums consisting of direct gross premiums, as defined in RCW 48.18.170, paid for insurance written or renewed upon risks or property resident, situated, or to be performed in this state, less return premiums and premiums on policies not taken, dividends paid or credited to policyholders on direct business, and premiums received from policies or contracts issued in connection with qualified plans as defined in RCW 48.14.021((~~, and~~)); (B) prepayments to health care service contractors, as defined in RCW 48.44.010, health maintenance organizations, as defined in RCW 48.46.020, or participant contributions to self-funded multiple employer welfare arrangements, as defined in RCW 48.125.010, less experience rating credits, dividends, prepayments returned to subscribers, and payments for contracts not taken; and (C) any money

1 received for coverage under contracts issued on behalf of the program
2 created in chapter 70.-- RCW (the new chapter created in section 40 of
3 this act).
4 (ii) Participant contributions, under chapter 48.125 RCW, used to
5 determine the receipts in this state under this section shall be
6 determined in the same manner as premiums taxable in this state are
7 determined under RCW 48.14.090.
8 (c) "Regulatory surcharge" means the fees imposed by this section.
9 (2) The annual cost of operating the office of insurance
10 commissioner shall be determined by legislative appropriation. A pro
11 rata share of the cost shall be charged to all organizations as a
12 regulatory surcharge. Each class of organization shall contribute a
13 sufficient amount to the insurance commissioner's regulatory account to
14 pay the reasonable costs, including overhead, of regulating that class
15 of organization.
16 (3) The regulatory surcharge shall be calculated separately for
17 each class of organization. The regulatory surcharge collected from
18 each organization shall be that portion of the cost of operating the
19 insurance commissioner's office, for that class of organization, for
20 the ensuing fiscal year that is represented by the organization's
21 portion of the receipts collected or received by all organizations
22 within that class on business in this state during the previous
23 calendar year. However, the regulatory surcharge must not exceed one-
24 eighth of one percent of receipts and the minimum regulatory surcharge
25 shall be one thousand dollars.
26 (4) The commissioner shall annually, on or before June 1st,
27 calculate and bill each organization for the amount of the regulatory
28 surcharge. The regulatory surcharge shall be due and payable no later
29 than June 15th of each year. However, if the necessary financial
30 records are not available or if the amount of the legislative
31 appropriation is not determined in time to carry out such calculations
32 and bill such regulatory surcharge within the time specified, the
33 commissioner may use the regulatory surcharge factors for the prior
34 year as the basis for the regulatory surcharge and, if necessary, the
35 commissioner may impose supplemental fees to fully and properly charge
36 the organizations. Any organization failing to pay the regulatory
37 surcharges by June 30th shall pay the same penalties as the penalties

for failure to pay taxes when due under RCW 48.14.060. The regulatory surcharge required by this section is in addition to all other taxes and fees now imposed or that may be subsequently imposed.

(5) All moneys collected shall be deposited in the insurance commissioner's regulatory account in the state treasury which is hereby created.

(6) Unexpended funds in the insurance commissioner's regulatory account at the close of a fiscal year shall be carried forward in the insurance commissioner's regulatory account to the succeeding fiscal year and shall be used to reduce future regulatory surcharges. During the 2007-2009 fiscal biennium, the legislature may transfer from the insurance commissioner's regulatory account to the Washington state heritage center account such amounts as reflect excess fund balance in the account.

(7)(a) Each insurer may annually collect regulatory surcharges remitted in preceding years by means of a policyholder surcharge on premiums charged for all kinds of insurance. The recoupment shall be at a uniform rate reasonably calculated to collect the regulatory surcharge remitted by the insurer.

(b) If an insurer fails to collect the entire amount of the recoupment in the first year under this section, it may repeat the recoupment procedure provided for in this subsection (7) in succeeding years until the regulatory surcharge is fully collected or a de minimis amount remains uncollected. Any such de minimis amount may be collected as provided in (d) of this subsection.

(c) The amount and nature of any recoupment shall be separately stated on either a billing or policy declaration sent to an insured. The amount of the recoupment must not be considered a premium for any purpose, including the premium tax or agents' commissions.

(d) An insurer may elect not to collect the regulatory surcharge from its insured. In such a case, the insurer may recoup the regulatory surcharge through its rates, if the following requirements are met:

(i) The insurer remits the amount of surcharge not collected by election under this subsection; and

(ii) The surcharge is not considered a premium for any purpose, including the premium tax or agents' commission.

1 NEW SECTION. **Sec. 24.** The legislature recognizes that every
2 individual possesses a fundamental right to exercise his or her
3 religious beliefs and conscience. The legislature further recognizes
4 that in developing public policy, conflicting religious and moral
5 beliefs must be respected. The state also recognizes the right of
6 individuals enrolled in the program to receive the full range of
7 services covered under the program. Therefore:
8 (1) No person may be required by law or contract to participate in
9 the provision of or payment for a specific service if the person
10 objects to doing so for reason of conscience or religion.
11 (2) The authority shall establish a mechanism to recognize the
12 right to exercise conscience while ensuring enrollees have timely
13 access to services and ensuring prompt payment to service providers.

14 NEW SECTION. **Sec. 25.** (1) All persons appointed by participating
15 carriers to assist in the choosing of and registering with a carrier,
16 other than persons providing only ministerial duties and employees of
17 any agency of the state, must be appropriately licensed by the
18 commissioner as producers and must comply with the requirements of
19 chapter 48.17 RCW.
20 (2) When an eligible person is assisted in choosing and registering
21 with a participating carrier by a licensed producer, the carrier chosen
22 by the enrollee must pay the producer a commission.
23 (a) The amount of the commission must be set forth in a rule
24 adopted by the authority.
25 (b) When establishing the amount of the commission, the authority
26 must consider the rates of commission paid to producers by carriers for
27 health plans other than this program.
28 (c) Preference in commission rates may be given to producers who
29 assist with enrollment of eligible persons who reside in rural or
30 underserved areas of the state.

31 NEW SECTION. **Sec. 26.** Employers must make information developed
32 by the authority about the program and open enrollment available to
33 their employees.

34 NEW SECTION. **Sec. 27.** (1) The guaranteed benefit program trust
35 account is established in the custody of the state treasurer. All

1 receipts from the deposit of reserves, dividends, and refunds must be
2 deposited into the account. Expenditures from the account may be used
3 only for payment of premiums to participating carriers, to establish
4 and maintain appropriate reserves or rate stabilization funds, and for
5 operating expenses of the program.

6 (a) Expenditures from the account must be disbursed by the state
7 treasurer by warrants on vouchers authorized by the authority.

8 (b) Moneys in the account, including unanticipated revenues under
9 RCW 43.79.270, may be spent only after allocation.

10 (2) The account is subject to allotment procedures under chapter
11 43.88 RCW, but an appropriation is not required for expenditures.

12 (3) The authority must keep full and adequate records and accounts
13 of the assets, obligations, transactions, and affairs of the program
14 created under this chapter.

15 (4) The state investment board shall act as the investor for the
16 funds and, except as provided in RCW 43.33A.160 and 43.84.160, one
17 hundred percent of all earnings from these investments must accrue
18 directly to the fund.

19 NEW SECTION. **Sec. 28.** (1) The guaranteed benefit program reserve
20 trust account is created in the custody of the state treasurer. All
21 receipts from reserves established for self-funded benefits, if any,
22 must be deposited into the account. Expenditures from the account may
23 only be used for the establishment of appropriate reserves, payment of
24 benefits for eligible enrollees, and operating expenses of any self-
25 funded program. Only the authority may authorize expenditures from the
26 account. The account is subject to allotment procedures under chapter
27 43.88 RCW, but an appropriation is not required for expenditures.

28 (2) The account is subject to the examination requirements of
29 chapter 48.03 RCW as if the program were a domestic insurer. In
30 conducting this examination, the commissioner is authorized to
31 determine the adequacy of the reserves established for the program.

32 (3) The authority shall file periodic statements of the financial
33 condition, transactions, and affairs of any self-funded option
34 established under the program established under this section in a form
35 and manner prescribed by the commissioner. A copy of the annual
36 statement must be filed with the governor, the speaker of the house of

1 representatives, and the president of the senate within four months
2 after the end of the coverage year.

3 **Sec. 29.** RCW 43.79A.040 and 2008 c 239 s 9, 2008 c 208 s 9, 2008
4 c 128 s 20, and 2008 c 122 s 24 are each reenacted and amended to read
5 as follows:
6 (1) Money in the treasurer's trust fund may be deposited, invested,
7 and reinvested by the state treasurer in accordance with RCW 43.84.080
8 in the same manner and to the same extent as if the money were in the
9 state treasury.
10 (2) All income received from investment of the treasurer's trust
11 fund shall be set aside in an account in the treasury trust fund to be
12 known as the investment income account.
13 (3) The investment income account may be utilized for the payment
14 of purchased banking services on behalf of treasurer's trust funds
15 including, but not limited to, depository, safekeeping, and
16 disbursement functions for the state treasurer or affected state
17 agencies. The investment income account is subject in all respects to
18 chapter 43.88 RCW, but no appropriation is required for payments to
19 financial institutions. Payments shall occur prior to distribution of
20 earnings set forth in subsection (4) of this section.
21 (4)(a) Monthly, the state treasurer shall distribute the earnings
22 credited to the investment income account to the state general fund
23 except under (b) and (c) of this subsection.
24 (b) The following accounts and funds shall receive their
25 proportionate share of earnings based upon each account's or fund's
26 average daily balance for the period: The Washington promise
27 scholarship account, the college savings program account, the
28 Washington advanced college tuition payment program account, the
29 agricultural local fund, the American Indian scholarship endowment
30 fund, the foster care scholarship endowment fund, the foster care
31 endowed scholarship trust fund, the students with dependents grant
32 account, the basic health plan self-insurance reserve account, the
33 contract harvesting revolving account, the Washington state combined
34 fund drive account, the commemorative works account, the Washington
35 international exchange scholarship endowment fund, the toll collection
36 account, the developmental disabilities endowment trust fund, the
37 energy account, the fair fund, the family leave insurance account, the

1 food animal veterinarian conditional scholarship account, the fruit and
2 vegetable inspection account, the future teachers conditional
3 scholarship account, the game farm alternative account, the GET ready
4 for math and science scholarship account, the grain inspection
5 revolving fund, <u>the guaranteed benefit program reserve trust account,</u>
6 <u>the guaranteed benefit program trust account,</u> the juvenile
7 accountability incentive account, the law enforcement officers' and
8 firefighters' plan 2 expense fund, the local tourism promotion account,
9 the pilotage account, the produce railcar pool account, the regional
10 transportation investment district account, the rural rehabilitation
11 account, the stadium and exhibition center account, the youth athletic
12 facility account, the self-insurance revolving fund, the sulfur dioxide
13 abatement account, the children's trust fund, the Washington horse
14 racing commission Washington bred owners' bonus fund account, the
15 Washington horse racing commission class C purse fund account, the
16 individual development account program account, the Washington horse
17 racing commission operating account (earnings from the Washington horse
18 racing commission operating account must be credited to the Washington
19 horse racing commission class C purse fund account), the life sciences
20 discovery fund, the Washington state heritage center account, the
21 reduced cigarette ignition propensity account, and the reading
22 achievement account. However, the earnings to be distributed shall
23 first be reduced by the allocation to the state treasurer's service
24 fund pursuant to RCW 43.08.190.
25 (c) The following accounts and funds shall receive eighty percent
26 of their proportionate share of earnings based upon each account's or
27 fund's average daily balance for the period: The advanced right-of-way
28 revolving fund, the advanced environmental mitigation revolving
29 account, the city and county advance right-of-way revolving fund, the
30 federal narcotics asset forfeitures account, the high occupancy vehicle
31 account, the local rail service assistance account, and the
32 miscellaneous transportation programs account.
33 (5) In conformance with Article II, section 37 of the state
34 Constitution, no trust accounts or funds shall be allocated earnings
35 without the specific affirmative directive of this section.

36 <u>NEW SECTION.</u> **Sec. 30.** The state auditor shall examine the records

1 of the program every second year, or more frequently upon request of
2 the board, and may recommend methods of accounting and the rendering of
3 periodic reports of projects undertaken by the board.

4 NEW SECTION. **Sec. 31.** A new section is added to chapter 42.56 RCW
5 to read as follows:
6 (1) The following information is exempt from disclosure under this
7 chapter:
8 (a) Records obtained by or on file with any carrier or the
9 authority containing information concerning the medical history or
10 treatment of any person, a person's financial information, and a
11 person's social security number;
12 (b) Actuarial formula, statistics, and assumptions submitted in
13 support of or in response to a request for proposals as part of a
14 competitive bid or submitted to or at the request of the authority; and
15 (c) Actuarial formulas, statistics, cost and utilization data, or
16 other proprietary information submitted upon request of the authority
17 may be withheld at any time from public inspection when necessary to
18 preserve trade secrets or prevent unfair competition.
19 (2) When soliciting proposals for the purpose of awarding contracts
20 for goods or services related to the program, the authority, upon
21 written request of the bidder, shall exempt from public inspection and
22 copying such proprietary data, trade secrets, or other information
23 contained in the bidder's proposal that relate to the bidder's unique
24 methods of conducting business or of determining prices or premium
25 rates to be charged for services under terms of the proposal.
26 (3) The definitions in section 2 of this act apply throughout this
27 section unless the context clearly requires otherwise.

28 NEW SECTION. **Sec. 32.** (1) The secretary of the department of
29 social and health services shall seek all necessary waivers or
30 amendments needed for full implementation of the program and shall seek
31 to obtain federal reimbursements for all eligible persons who enroll in
32 the program.
33 (2) The secretary of the department of social and health services
34 shall report to the governor, the legislature, the commissioner, and
35 the authority on the status of federal reimbursement and requests for
36 waivers or amendments. This includes any waiver requested or granted

by the federal department of health and human services under section 1115 of the social security act or such other waivers or amendments as the secretary may determine are necessary.

(3) The secretary of the department of social and health services shall consult with the board and other interested parties prior to submission of waivers and amendments to the federal department of health and human services.

(4) Rules adopted under the authority of this chapter must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

NEW SECTION. **Sec. 33.** If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state.

NEW SECTION. **Sec. 34.** (1) The commissioner shall study and report on whether to retain, eliminate, or change the Washington state health insurance pool, created in chapter 48.41 RCW, after full implementation of this program. The final report must be submitted to the governor and appropriate committees of the legislature by December 1st of a year that is no later than two years after the first registration occurs.

(2) The report must consider the following:

(a) The economic impact to the pool of implementing the program;

(b) The potential impact to residents of eliminating or changing the pool;

(c) Alternatives for coverage for existing members of the pool and persons who might require access to the pool for coverage to supplement the program if the pool were eliminated;

(d) The potential for cost savings to the state, residents, providers, and facilities, and carriers by eliminating or changing the pool;

1 (e) Alternative approaches to changing or winding down the pool;
2 and

3 (f) Any other factors the commissioner determines are relevant to
4 the question of whether the Washington state health insurance pool
5 should be retained, eliminated, or changed.

6 (3) In preparation of the report, the commissioner shall consult
7 with relevant parties, such as but not limited to the board and the
8 authority, the state office of financial management, the Washington
9 state health insurance pool board, carriers, providers (including
10 facilities), consumers, business, and labor.

11 NEW SECTION. **Sec. 35.** The authority shall report to the governor
12 and to the legislature on the effects of the program no later than
13 December 1st of a year that is no later than five years after full
14 implementation of the program and every odd-numbered year thereafter.

15 NEW SECTION. **Sec. 36.** The commissioner, the authority, and the
16 secretary of the department of social and health services may adopt
17 such rules as are necessary or desirable to implement this act.

18 **Sec. 37.** RCW 70.47.020 and 2007 c 259 s 35 are each amended to
19 read as follows:

20 As used in this chapter:

21 (1) "Washington basic health plan" or "plan" means the system of
22 enrollment and payment for basic health care services, administered by
23 the plan administrator through participating managed health care
24 systems, created by this chapter.

25 (2) "Administrator" means the Washington basic health plan
26 administrator, who also holds the position of administrator of the
27 Washington state health care authority.

28 (3) "Health coverage tax credit program" means the program created
29 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
30 credit that subsidizes private health insurance coverage for displaced
31 workers certified to receive certain trade adjustment assistance
32 benefits and for individuals receiving benefits from the pension
33 benefit guaranty corporation.

34 (4) "Health coverage tax credit eligible enrollee" means individual
35 workers and their qualified family members who lose their jobs due to

the effects of international trade and are eligible for certain trade adjustment assistance benefits; or are eligible for benefits under the alternative trade adjustment assistance program; or are people who receive benefits from the pension benefit guaranty corporation and are at least fifty-five years old.

(5) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(6) "Subsidized enrollee" means:

(a) An individual, or an individual plus the individual's spouse or dependent children:

(i) Who is not eligible for medicare;

(ii) Who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;

(iii) Who is not a full-time student who has received a temporary visa to study in the United States;

(iv) Who resides in an area of the state served by a managed health care system participating in the plan;

(v) Whose gross family income at the time of enrollment does not exceed ((~~two~~)) three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and

(vi) Who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan; and

(b) An individual who meets the requirements in (a)(i) through (iv) and (vi) of this subsection and who is a foster parent licensed under chapter 74.15 RCW and whose gross family income at the time of enrollment does not exceed three hundred percent of the federal poverty

1 level as adjusted for family size and determined annually by the
2 federal department of health and human services((~~; and~~

3 ~~(c) To the extent that state funds are specifically appropriated~~
4 ~~for this purpose, with a corresponding federal match, an individual, or~~
5 ~~an individual's spouse or dependent children, who meets the~~
6 ~~requirements in (a)(i) through (iv) and (vi) of this subsection and~~
7 ~~whose gross family income at the time of enrollment is more than two~~
8 ~~hundred percent, but less than two hundred fifty-one percent, of the~~
9 ~~federal poverty level as adjusted for family size and determined~~
10 ~~annually by the federal department of health and human services~~)).

11 (7) "Nonsubsidized enrollee" means an individual, or an individual
12 plus the individual's spouse or dependent children: (a) Who is not
13 eligible for medicare; (b) who is not confined or residing in a
14 government-operated institution, unless he or she meets eligibility
15 criteria adopted by the administrator; (c) who is accepted for
16 enrollment by the administrator as provided in RCW 48.43.018, either
17 because the potential enrollee cannot be required to complete the
18 standard health questionnaire under RCW 48.43.018, or, based upon the
19 results of the standard health questionnaire, the potential enrollee
20 would not qualify for coverage under the Washington state health
21 insurance pool; (d) who resides in an area of the state served by a
22 managed health care system participating in the plan; (e) who chooses
23 to obtain basic health care coverage from a particular managed health
24 care system; and (f) who pays or on whose behalf is paid the full costs
25 for participation in the plan, without any subsidy from the plan.

26 (8) "Subsidy" means the difference between the amount of periodic
27 payment the administrator makes to a managed health care system on
28 behalf of a subsidized enrollee plus the administrative cost to the
29 plan of providing the plan to that subsidized enrollee, and the amount
30 determined to be the subsidized enrollee's responsibility under RCW
31 70.47.060(2).

32 (9) "Premium" means a periodic payment, which an individual, their
33 employer or another financial sponsor makes to the plan as
34 consideration for enrollment in the plan as a subsidized enrollee, a
35 nonsubsidized enrollee, or a health coverage tax credit eligible
36 enrollee.

37 (10) "Rate" means the amount, negotiated by the administrator with

1 and paid to a participating managed health care system, that is based
2 upon the enrollment of subsidized, nonsubsidized, and health coverage
3 tax credit eligible enrollees in the plan and in that system.

4 NEW SECTION. **Sec. 38.** This chapter may be known and cited as the
5 guaranteed health benefit program act.

6 NEW SECTION. **Sec. 39.** If any provision of this act or its
7 application to any person or circumstance is held invalid, the
8 remainder of the act or the application of the provision to other
9 persons or circumstances is not affected.

10 NEW SECTION. **Sec. 40.** Sections 1 through 20, 24 through 28, 30,
11 32 through 36, 38, and 39 of this act constitute a new chapter in Title
12 70 RCW.

13 NEW SECTION. **Sec. 41.** The secretary of state shall submit this
14 act to the people for their adoption and ratification, or rejection, at
15 the next general election to be held in this state, in accordance with
16 Article II, section 1 of the state Constitution and the laws adopted to
17 facilitate its operation.

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