dependent upon either or both spouses to pay an amount reasonable or necessary for his support. The court may require annual adjustments of support based upon changes in a party's income or the child's needs, or based upon changes in an index or schedule.

NEW SECTION. Sec. 4. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Passed the House April 21, 1987.
Passed the Senate April 16, 1987.
Approved by the Governor May 18, 1987.
Filed in Office of Secretary of State May 18, 1987.

CHAPTER 431

[Engrossed Substitute House Bill No. 99]

HEALTH INSURANCE COVERAGE ACCESS ACT

AN ACT Relating to health insurance coverage access for those persons otherwise uninsurable; adding a new section to chapter 48.14 RCW; adding a new section to chapter 82.04 RCW; adding a new chapter to Title 48 RCW; creating a new section; and declaring an emergency.

Be it enacted by the Legislature of the State of Washington:

NEW SECTION. Sec. 1. This chapter shall be known and may be cited as the "Washington state health insurance coverage access act".

NEW SECTION. Sec. 2. It is the purpose and intent of the legislature to provide access to health insurance coverage to all residents of Washington who are denied adequate health insurance for any reason. It is the intent of the legislature that adequate levels of health insurance coverage be made available to residents of Washington who are otherwise considered uninsurable or who are underinsured. It is the intent of the Washington state health insurance coverage access act to provide a mechanism to insure the availability of comprehensive health insurance to persons unable to obtain such insurance coverage on either an individual or group basis directly under any health plan.

NEW SECTION. Sec. 3. As used in this chapter, the following terms have the meaning indicated, unless the context requires otherwise:

(1) "Administrator" means the entity chosen by the board to administer the pool under section 8 of this act.

(2) "Board" means the board of directors of the pool.

(3) "Commissioner" means the insurance commissioner.

(4) "Health care facility" has the same meaning as in RCW 70.38.025.

(5) "Health care provider" means any physician, facility, or health care professional, who is licensed in Washington state and entitled to reimbursement for health care services.

(6) "Health care services" means services for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(7) "Health insurance" means any group or individual disability insurance policy, health care service contract, and health maintenance agreement, except those contracts entered into for the provision of health care services pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 et seq. The term does not include short-term care, long-term care, dental, vision, accident, fixed indemnity, disability income contracts, civilian health and medical program for the uniform services (CHAMPUS), 10 U.S.C. 55, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the worker's compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(8) "Health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under this pool, have access to hospital and medical benefits or reimbursement including any group or individual disability insurance policy; health care service contract; health maintenance agreement; uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus, or other benefit methodologies not involving insurance or not governed by Title 48 RCW; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by medicare or other governmental benefits. This term includes coverage through "health insurance" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health insurance" in subsection (7) of this section.

(9) "Insured" means any individual resident of this state who is eligible to receive benefits from any member, or other health plan.

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

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

(12) "Member" means any commercial insurer which provides disability insurance, any health care service contractor, and any health maintenance organization licensed under Title 48 RCW. "Member" shall also mean, as soon as authorized by federal law, employers and other entities,

including a self-funding entity and employee welfare benefit plans that provide health plan benefits in this state on or after the effective date of this section. "Member" does not include any insurer, health care service contractor, or health maintenance organization whose products are exclusively dental products.

(13) "Plan of operation" means the pool, including articles, by-laws, and operating rules, adopted by the board pursuant to section 5 of this act.

(14) "Pool" means the Washington state health insurance pool as created in section 4 of this act.

(15) "Substantially equivalent health plan" means a "health plan" as defined in subsection (8) of this section which, in the judgment of the board or the administrator, offers persons including dependents or spouses covered or making application to be covered by this pool an overall level of benefits deemed approximately equivalent to the minimum benefits available under this pool.

NEW SECTION. Sec. 4. (1) There is hereby created a nonprofit entity to be known as the Washington state health insurance pool. All members in this state on or after the effective date of this section shall be members of the pool. When authorized by federal law, all self-insured employers as designated by federal law shall also be members of the pool.

(2) Pursuant to chapter 34.04 RCW the commissioner shall, within ninety days after the effective date of this section, give notice to all members of the time and place for the initial organizational meetings of the pool. A board of directors shall be established, which shall be comprised of nine members. The commissioner shall select three members of the board who shall represent (a) the general public, (b) health care providers, and (c) health insurance agents. The remaining members of the board shall be selected by election from among the members of the pool. The elected members shall, to the extent possible, include at least one representative of health care service contractors, one representative of health maintenance organizations, and one representative of commercial insurers which provides disability insurance. When self-insured organizations become eligible for participation in the pool, one member of the board shall represent the self-insurers.

(3) The original members of the board of directors shall be appointed for intervals of one to three years. Thereafter, all board members shall serve a term of three years. Board members shall receive no compensation, but shall be reimbursed for all travel expenses as provided in RCW 43.03.050 and 43.03.060.

(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing pursuant to chapter 34.04 RCW, approve the

plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board or any time thereafter fails to submit acceptable amendments to the plan, the commissioner shall, within ninety days after notice and hearing pursuant to chapters 34.04 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.

NEW SECTION. Sec. 5. The plan of operation submitted by the board to the commissioner shall:

(1) Establish procedures for the handling and accounting of assets and moneys of the pool;

(2) Establish regular times and places for meetings of the board of directors;

(3) Establish procedures for records to be kept of all financial transactions and for an annual fiscal reporting to the commissioner;

(4) Contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

(5) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) Establish the amount of assessment pursuant to section 6 of this act, which shall occur after March 1st of each calendar year, and which shall be due and payable within thirty days of the receipt of the assessment notice;

(7) Select an administrator in accordance with section 8 of this act;

(8) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of the plan; and

(9) Establish procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board.

NEW SECTION. Sec. 6. The board shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under this title. In addition thereto, the board may:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter including the authority, with the approval of the commissioner, to enter into contracts with similar pools of

other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

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

(3) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices;

(4) Assess members of the pool in accordance with the provisions of this chapter, and to make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim expenses will be credited as offsets against any regular assessments due following the close of the calendar year;

(5) Issue policies of insurance in accordance with the requirements of this chapter;

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

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

NEW SECTION. Sec. 7. The pool shall be subject to examination by the commissioner as provided under chapter 48.03 RCW. The board of directors shall submit, not later than March 1st of each year, a financial report for the preceding calendar year in a form approved by the commissioner. The board of directors shall further report to the appropriate standing committees of each house of the legislature by March 1st of each year.

NEW SECTION. Sec. 8. The board shall select an administrator through a competitive bidding process to administer the pool.

(1) The board shall evaluate bids based upon criteria established by the board, which shall include:

(a) The administrator's proven ability to handle accident and health insurance;

(b) The efficiency of the administrator's claim-paying procedures;

(c) An estimate of the total charges for administering the plan; and

(d) The administrator's ability to administer the pool in a cost-effective manner.

(2) The administrator shall serve for a period of three years subject to removal for cause. At least one year prior to the expiration of each three-year period of service by the administrator, the board shall invite all interested parties, including the current administrator, to submit bids to serve as the administrator for the succeeding three-year period. Selection of the administrator for this succeeding period shall be made at least six months prior to the end of the current three-year period.

(3)(a) The administrator shall perform all eligibility and administrative claim payment functions relating to the pool;

(b) The administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing;

(c) The administrator shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(i) Making available information relating to the proper manner of submitting a claim for benefits to the pool, and distributing forms upon which submission shall be made; and

(ii) Evaluating the eligibility of each claim for payment by the pool;

(d) The administrator shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board;

(e) Following the close of each calendar year, the administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the commissioner on a form as prescribed by the commissioner;

(f) The administrator shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

NEW SECTION. Sec. 9. (1) Following the close of each calendar year, the pool administrator shall determine the net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses.

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

persons including spouses and dependents insured under all health plans in the state by pool members.

(b) Any deficit incurred by the pool shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members.

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

(4) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

NEW SECTION. Sec. 10. (1) Any individual person who is a resident of this state is eligible for coverage upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up–rated premium, or a preexisting conditions limitation on health insurance, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one member within six months of the date of application.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person who is at the time of pool application eligible for medical assistance;

(b) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums;

(c) Any person on whose behalf the pool has paid out five hundred thousand dollars in benefits;

(d) Inmates of public institutions and persons whose benefits are duplicated under public programs.

(3) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan.

NEW SECTION. Sec. 11. (1) The administrator shall prepare a brochure outlining the benefits and exclusions of the pool policy in plain language. After approval by the board of directors, such brochure shall be made reasonably available to participants or potential participants. The health insurance policy issued by the pool shall pay only usual, customary,

and reasonable charges for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illnesses, injuries, and conditions which are not otherwise limited or excluded. Eligible expenses are the usual, customary, and reasonable charges for the health care services and items for which benefits are extended under the pool policy. Such benefits shall at minimum include, but not be limited to, the following services or related items:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty inpatient days in a calendar year, and limited to thirty days inpatient care for mental and nervous conditions, or alcohol, drug, or chemical dependency or abuse per calendar year;

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

(c) The first twenty outpatient professional visits for the diagnosis or treatment of one or more mental or nervous conditions or alcohol, drug, or chemical dependency or abuse rendered during a calendar year by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners:

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

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

(n) Services of a physical therapist and services of a speech therapist;

(o) Hospice services;

(p) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury; and

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

(2) The board shall design and employ cost containment measures and requirements such as, but not limited to, preadmission certification and concurrent inpatient review which may make the pool more cost-effective.

(3) The pool benefit policy may contain benefit limitations, exceptions, and reductions that are generally included in health insurance plans and are approved by the insurance commissioner; however, no limitation, exception, or reduction may be approved that would exclude coverage for any disease, illness, or injury.

NEW SECTION. Sec. 12. (1) Subject to the limitation provided in subsection (3) of this section, a pool policy offered in accordance with this chapter shall impose a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

(2) Subject to the limitations provided in subsection (3) of this section, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.

(3) The maximum aggregate out of pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance shall not exceed in a policy year:

(a) One thousand five hundred dollars per individual, or three thousand dollars per family, per policy year for the five hundred dollar deductible policy;

(b) Two thousand five hundred dollars per individual, or five thousand dollars per family per policy year for the one thousand dollar deductible policy; or

(c) An amount authorized by the board for any other deductible policy.

(4) Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

NEW SECTION. Sec. 13. All policy forms issued by the pool shall conform in substance to prototype forms developed by the pool, and shall in all other respects conform to the requirements of this chapter, and shall be filed with and approved by the commissioner before they are issued. The pool shall not issue a pool policy to any individual who, on the effective date

of the coverage applied for, already has or would have coverage substantially equivalent to a pool policy as an insured or covered dependent, or who would be eligible for such coverage if he elected to obtain it at a lesser premium rate.

NEW SECTION. Sec. 14. (1) Coverage shall provide that health insurance benefits are applicable to children of the person in whose name the policy is issued including adopted and newly born natural children. Coverage shall also include necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the policy may require that notification of the birth or adoption of a child and payment of the required premium must be furnished to the pool within thirty-one days after the date of birth or adoption in order to have the coverage continued beyond the thirty-one day period. For purposes of this subsection, a child is deemed to be adopted, and benefits are payable, when the child is physically placed for purposes of adoption under the laws of this state with the person in whose name the policy is issued; and, when the person in whose name the policy is issued assumes financial responsibility for the medical expenses of the child. For purposes of this subsection, "newly born" means, and benefits are payable, from the moment of birth.

(2) A pool policy shall provide that coverage of a dependent, unmarried person shall terminate when the person becomes nineteen years of age: PROVIDED, That coverage of such person shall not terminate at age nineteen while he or she is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability or physical handicap and (b) chiefly dependent upon the person in whose name the policy is issued for support and maintenance, provided proof of such incapacity and dependency is furnished to the pool by the policy holder within thirty-one days of the dependent's attainment of age nineteen and subsequently as may be required by the pool but not more frequently than annually after the two-year period following the dependent's attainment of age nineteen.

(3) A pool policy may contain provisions under which coverage is excluded during a period of six months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of six months before the effective date of coverage.

These preexisting condition exclusions shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance which was for any reason other than nonpayment of premium involuntarily terminated, if the application for pool coverage is made not later than thirty days following the involuntary termination. In that case, with payment of appropriate premium, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

NEW SECTION. Sec. 15. (1) The board shall offer a medical supplement policy for persons receiving medicare benefits. The supplement policy shall provide coverage of one hundred percent of the deductible and copayment required under medicare and eighty percent of the charges for covered services under this chapter that are not paid by medicare. The coverage shall include a limitation of one thousand dollars per person on total annual out–of–pocket expenses for the covered services.

(2) If federal law is adopted that addresses this subject, the board shall offer a policy that is consistent with that federal law.

NEW SECTION. Sec. 16. (1) A pool policy offered under this chapter shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with section 15 of this act.

(2) The pool may not change the rates for pool policies except on a class basis, with a clear disclosure in the policy of the pool's right to do so.

(3) A pool policy offered under this chapter shall provide that, upon the death of the individual in whose name the policy is issued, every other individual then covered under the policy may elect, within a period specified in the policy, to continue coverage under the same or a different policy.

NEW SECTION. Sec. 17. The commissioner shall adopt rules pursuant to chapter 34.04 RCW that:

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

(2) Implement this chapter.

NEW SECTION. Sec. 18. (1) Commencing with the effective date of this section, every member shall provide a notice and an application for coverage by the pool to any person who receives a rejection of coverage for health insurance or health care services, or has any health condition limited or excluded. The notice shall state that the person is eligible to apply for health insurance provided by the pool.

(2) Members of the pool shall provide the brochure outlining the benefits and exclusions of the pool policy to any person who is rejected by a member or who is offered a policy containing restrictive riders, up–rated premiums, or a preexisting conditions limitation on a health insurance plan.

NEW SECTION. Sec. 19. Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal

liability or penalty against the pool or members of it either jointly or separately.

NEW SECTION. Sec. 20. The pool shall determine the standard risk rate by calculating the average group standard rate for groups comprised of up to ten persons charged by the five largest members offering coverages in the state comparable to the pool coverage. In the event five members do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Maximum rates for pool coverage shall be one hundred fifty percent of the rates established as applicable for group standard risks in groups comprised of up to ten persons. All rates and rate schedules shall be submitted to the commissioner for approval.

NEW SECTION. Sec. 21. It is the express intent of this chapter that the pool be the last payor of benefits whenever any other benefit is available.

(1) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or health benefit plans, including but not limited to self–insured plans and by all hospital and medical expense benefits paid or payable under 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 state or federal law or program.

(2) The administrator or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set–off against any amount recoverable under this subsection.

NEW SECTION. Sec. 22. If any part of this chapter is found to be in conflict with federal requirements which are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this chapter is hereby declared to be inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and such finding or determination shall not affect the operation of the remainder of this chapter in its application to the agencies concerned. The rules under this chapter shall meet federal requirements which are a necessary condition to the receipt of federal funds by the state.

NEW SECTION. Sec. 23. A new section is added to chapter 48.14 RCW to read as follows:

(1) The taxes imposed in RCW 48.14.020 do not apply to premiums collected or received for policies of insurance issued under sections 1 through 21 of this act.

(2) In computing tax due under RCW 48.14.020, there may be deducted from taxable premiums the amount of any assessment against the

taxpayer under sections 1 through 21 of this act. Any portion of the deduction allowed in this section which cannot be deducted in a tax year without reducing taxable premiums below zero may be carried forward and deducted in successive years until the deduction is exhausted.

NEW SECTION. Sec. 24. A new section is added to chapter 82.04 RCW to read as follows:

In computing tax there may be deducted from the measure of tax the amount of any assessment against the taxpayer under sections 1 through 21 of this act. Any portion of the deduction allowed in this section which cannot be deducted in a tax year without reducing taxable premiums below zero may be carried forward and deducted in successive years until the deduction is exhausted. Amounts deducted under section 23 of this act may not be deducted under this section.

NEW SECTION. Sec. 25. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. Sec. 26. The board shall report to the commissioner and the appropriate committees of the legislature by April 1, 1990, on the implementation of this act. The report shall include information regarding enrollment, coverage utilization, cost, and any problems with the program and suggest remedies.

NEW SECTION. Sec. 27. Sections 1 through 22 of this act shall constitute a new chapter in Title 48 RCW.

NEW SECTION. Sec. 28. This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect immediately.

Passed the House April 20, 1987.
Passed the Senate April 13, 1987.
Approved by the Governor May 18, 1987.
Filed in Office of Secretary of State May 18, 1987.

CHAPTER 432

[Substitute House Bill No. 63]

LAKE MANAGEMENT DISTRICTS—RATES AND CHARGES—REVENUE BONDS—DISTRICT FORMATION

AN ACT Relating to lake management districts; amending RCW 36.61.010, 36.61.020, 36.61.030, 36.61.040, 36.61.070, 36.61.080, 36.61.090, 36.61.100, and 36.61.160; and adding new sections to chapter 36.61 RCW.

Be it enacted by the Legislature of the State of Washington: