

2 SHB 2018 - H AMD 313
3 By Representative Dyer

4

5 Strike everything after the enacting clause and insert the
6 following:

7 **"HEALTH INSURANCE REFORM**

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1 (1) "Certification" means a determination by a review organization
2 that an admission, extension of stay, or other health care service or
3 procedure has been reviewed and, based on the information provided,
4 meets the clinical requirements for medical necessity, appropriateness,
5 level of care, or effectiveness under the auspices of the applicable
6 health benefit plan.

7 (2) "Review organization" means an entity performing utilization
8 review, including a disability insurer regulated under chapter 48.20 or
9 48.21 RCW, health care service contractor as defined in RCW 48.44.010,
10 or health maintenance organization as defined in RCW 48.46.020, and
11 entities affiliated with, under contract with, or acting on behalf of
12 a health carrier.

13 (3) "Utilization review" means the prospective, concurrent, or
14 retrospective assessment of the necessity and appropriateness of the
15 allocation of health care resources and services of a provider or
16 facility, given or proposed to be given to an enrollee or group of
17 enrollees.

18 NEW SECTION. Sec. 103. A new section is added to chapter 41.05
19 RCW to read as follows:

20 UTILIZATION REVIEW--REVIEW ORGANIZATION. (1) Beginning on January
21 1, 1998, every review organization that performs utilization review of
22 inpatient medical and surgical benefits and outpatient medical and
23 surgical benefits for residents of this state shall meet the standards
24 set forth in this section and section 104 of this act.

25 (a) Review organizations shall comply with all applicable state and
26 federal laws to protect confidentiality of enrollee medical records.

27 (b) Any certification by a review organization as to the medical
28 necessity or appropriateness of an admission, length of stay, extension
29 of stay, or service or procedure must be made in accordance with
30 medical standards or guidelines approved by a licensed physician.

31 (c) Any determination by a review organization to deny an
32 admission, length of stay, extension of stay, or service or procedure
33 on the basis of medical necessity or appropriateness must be made by a
34 licensed physician who has reasonable access to board certified
35 specialty providers in making such determinations.

36 (d) Review organizations shall make staff available to perform
37 utilization review activities by toll-free or collect telephone, at
38 least forty hours per week during normal business hours.

1 (e) Review organizations shall have a phone system capable of
2 accepting or recording, or both, incoming phone calls during other than
3 normal business hours and shall respond to these calls within two
4 business days.

5 (f) Review organizations shall maintain a documented utilization
6 review program description and written utilization review criteria
7 based on reasonable medical evidence. The program must include a
8 method for reviewing and updating criteria. Review organizations shall
9 make utilization review criteria available upon request to the
10 participating provider involved in a specific case under review.

11 (g) Review organizations shall designate a licensed physician to
12 participate in utilization review program implementation.

13 (2) The Washington state health care authority shall periodically
14 examine review organization accreditation standards of the utilization
15 review accreditation commission, the national committee for quality
16 assurance, and other national accreditation organizations for
17 appropriateness and, if deemed appropriate, shall adopt rules exempting
18 a review organization from the requirements of section 104 of this act
19 if certified by a national credentialing entity approved by the
20 authority. The powers of the Washington state health care authority
21 set forth in this section are transferred to the office of the
22 insurance commissioner on January 1, 2001.

23 NEW SECTION. **Sec. 104.** A new section is added to chapter 41.05
24 RCW to read as follows:

25 UTILIZATION REVIEW--STANDARDS. (1) Notification of an initial
26 determination by the review organization to certify an admission,
27 length of stay, extension of stay, or service or procedure must be
28 mailed or otherwise communicated to the provider of record or the
29 enrollee, or the enrollee's authorized representative, or both, within
30 two business days of the determination and following the receipt of all
31 information necessary to complete the review.

32 (2) Notification of an initial determination by the review
33 organization to deny an admission, length of stay, extension of stay,
34 or service or procedure must be mailed or otherwise communicated to the
35 provider of record or the enrollee, or the enrollee's authorized
36 representative, or both, within one business day of the determination
37 and following the receipt of all information necessary to complete the
38 review.

1 (3) Any notification of a determination to deny an admission,
2 length of stay, extension of stay, or service or procedure must
3 include:

4 (a) The review organization's decision in clear terms and the
5 rationale in sufficient detail for the enrollee to respond further to
6 the review organization's decision; and

7 (b) The procedures to initiate an appeal of an adverse
8 determination.

9 (4) Health care facilities and providers shall cooperate with the
10 reasonable efforts of review organizations to ensure that all necessary
11 enrollee information is available in a timely fashion by phone during
12 normal business hours. Health care facilities and providers shall
13 allow on-site review of medical records by review organizations. These
14 provisions are subject to the requirements regarding health care
15 information disclosure in chapter 70.02 RCW.

16 NEW SECTION. **Sec. 105.** A new section is added to chapter 41.05
17 RCW to read as follows:

18 UTILIZATION REVIEW--LIMITED RECORD ACCESS. In performing a
19 utilization review, a review organization is limited to access to
20 specific health carrier information necessary to complete the review
21 being performed.

22 NEW SECTION. **Sec. 106.** GRIEVANCE PROCEDURES--INTENT. The
23 legislature is committed to the efficient use of state resources in
24 promoting public health and protecting the rights of individuals in the
25 state of Washington. The purpose of this act is to provide standards
26 for the establishment and maintenance of procedures by health carriers
27 to assure that covered persons have the opportunity for the appropriate
28 resolution of their grievances, as defined in this act.

29 NEW SECTION. **Sec. 107.** A new section is added to chapter 48.43
30 RCW to read as follows:

31 GRIEVANCE PROCEDURES--STANDARDS. (1) Every health carrier shall
32 use written procedures for receiving and resolving grievances from
33 covered persons. At each level of review of a grievance, the health
34 carrier shall include a person or persons with sufficient background
35 and authority to deliberate the merits of the grievance and establish
36 appropriate terms of resolution. The health carrier's medical director

1 or designee shall be available to participate in the review of any
2 grievance involving a clinical issue or issues. A grievance that
3 includes an issue of clinical quality of care as determined by the
4 health carrier's medical director or designee may be directed to the
5 health carrier's quality assurance committee for review and comment.
6 Nothing in this section alters any protections afforded under statutes
7 relating to confidentiality and nondiscoverability of quality assurance
8 activities and information.

9 (2)(a) A complaint that is not submitted in writing may be resolved
10 directly by the health carrier with the covered person, and is not
11 considered a grievance subject to the review, recording, and reporting
12 requirements of this section.

13 (b) The health carrier is required to provide telephone access to
14 covered persons for purposes of presenting a complaint for review.
15 Each telephone number provided shall be toll free or collect within the
16 health carrier's service area and provide reasonable access to the
17 health carrier without undue delays during normal business hours.

18 (3)(a) A grievance may be submitted by a covered person or a
19 representative acting on behalf of the covered person through written
20 authority to assure protection of the covered person's private
21 information. Within three working days of receiving a grievance, the
22 health carrier shall acknowledge in writing the receipt of the
23 grievance and the department name and address where additional
24 information may be submitted by the covered person or authorized
25 representative of the covered person. The health carrier shall process
26 the grievance in a reasonable length of time not to exceed thirty days
27 from receipt of the written grievance. If the grievance involves the
28 collection of information from sources external to the health carrier
29 and its participating providers, the health carrier has an additional
30 thirty days to process the covered person's grievance.

31 (b) The health carrier shall provide the covered person, or
32 authorized representative of the covered person, with a written
33 determination of its review within the time frame specified in (a) of
34 this subsection. The written determination shall contain at a minimum:

35 (i) The health carrier's decision in clear terms and the rationale
36 in sufficient detail for the covered person or authorized
37 representative of the covered person to respond further to the health
38 carrier's decision; and

1 (ii) When the health carrier's decision is not wholly favorable to
2 the covered person, a description of the process to obtain a second
3 level grievance review of the decision, including the time frames
4 required for submission of a request by the covered person or
5 authorized representative of the covered person.

6 (4)(a) A health carrier shall provide a second level grievance
7 review for those covered persons who are dissatisfied with the first
8 level grievance review decision and who submit a written request for
9 review. The second level review process shall include an opportunity
10 for the covered person or authorized representative of the covered
11 person to appear in person before the representative or representatives
12 of the health carrier. The covered person or authorized representative
13 of the covered person must ask for a personal appearance in the written
14 request for a second level review.

15 (b) The health carrier shall process the grievance in a reasonable
16 length of time, not to exceed thirty days from receipt of the request
17 for a second level review. The time required to resolve the second
18 level review may be extended for a specified period if mutually agreed
19 upon by the covered person or authorized representative of the covered
20 person and the health carrier.

21 (c) A health carrier's procedures for conducting a second level
22 review must include the following:

23 (i) The second level review panel shall be comprised of
24 representatives of the health carrier not otherwise participating in
25 the first level review. If the grievance involves a clinical issue or
26 issues, the health carrier shall appoint a health care professional
27 with appropriate qualifications who was not previously involved with
28 the grievance under review and shall ensure reasonable access to board-
29 certified specialty providers as typically manage the issue under
30 review;

31 (ii) The review panel shall schedule the review meeting to
32 reasonably accommodate the covered person or authorized representative
33 of the covered person and not unreasonably deny a request for
34 postponement of the review requested by the covered person or
35 authorized representative of the covered person; and

36 (iii) The health carrier shall notify the covered person or
37 authorized representative of the covered person in writing at least
38 fifteen days in advance of the scheduled review date unless a shorter
39 time frame is agreed to by the health carrier and the covered person.

1 The review meeting shall be held at a location within the health
2 carrier's service area that is reasonably accessible to the covered
3 person or authorized representative of the covered person. In cases
4 where a face-to-face meeting is not practical for geographic reasons,
5 a health carrier shall offer the covered person or authorized
6 representative of the covered person the opportunity to communicate
7 with the review panel, at the health carrier's expense, by conference
8 call, video conferencing, or other appropriate technology as determined
9 by the health carrier.

10 (d) The health carrier shall issue a written decision to the
11 covered person or authorized representative of the covered person
12 within five working days of completing the review meeting. The
13 decision shall include:

14 (i) A statement of the health carrier's understanding of the nature
15 of the grievance and all pertinent facts;

16 (ii) The health carrier's decision in clear terms and the rationale
17 for the review panel's decision; and

18 (iii) Notice of the covered person's right to any further review by
19 the health carrier.

20 (e) Determination of a grievance at the final level review that is
21 unfavorable to the covered person may be submitted by the covered
22 person or authorized representative of the covered person to nonbinding
23 mediation. Mediation shall be conducted under mediation rules similar
24 to those of the American arbitration association, the center for public
25 resources, the judicial arbitration and mediation service, RCW
26 7.70.100, or any other rules of mediation agreed to by the parties.

27 (5) Each health carrier as defined in this chapter shall file with
28 the commissioner its procedures for review and adjudication of
29 grievances initiated by covered persons.

30 (6) The health carrier shall maintain accurate records of each
31 grievance to include the following:

32 (a) A description of the grievance, the date received by the health
33 carrier, and the name and identification number of the covered person;
34 and

35 (b) A statement as to which level of the grievance procedure the
36 grievance has been brought, the date at which it was brought to each
37 level, the decision reached at each level, and a summary description of
38 the rationale for the decision.

1 (7) Each health carrier shall make an annual report available to
2 the commissioner. The report shall include for each type of health
3 benefit plan offered by the health carrier: The number of covered
4 lives; the total number of grievances received divided into the
5 following categories: Access, health carrier customer service, health
6 care provider or facility service, claim payment, and dispute
7 resolution; the number of grievances resolved at each level; and the
8 total number of favorable and unfavorable decisions.

9 (8) A notice of the availability and the requirements of the
10 grievance procedure, including the address where a written grievance
11 may be filed, shall be included in or attached to the policy,
12 certificate, membership booklet, outline of coverage, or other evidence
13 of coverage provided by the health carrier to its enrollees.

14 (9) The notice shall include a toll-free telephone number for a
15 covered person to obtain verbal explanation of the grievance procedure.

16 (10) A health carrier shall establish written procedures for the
17 expedited review of a grievance involving a situation where the time to
18 resolve a grievance according to the procedures set forth in this
19 section would seriously jeopardize the life or health of a covered
20 person. A request for an expedited review may be submitted orally or
21 in writing by a covered person or authorized representative of the
22 covered person. A health carrier's procedures for establishing an
23 expedited review process shall include the following:

24 (a) The health carrier shall appoint an appropriate health care
25 professional to participate in expedited reviews and shall provide
26 reasonable access to board-certified specialty providers as typically
27 manage the issue under review.

28 (b) A health carrier shall provide expedited review to all requests
29 concerning an admission, availability of care, continued stay, or
30 review of a health care service for a covered person who has received
31 emergency services but has not been discharged from a facility.

32 (c) All necessary information, including the health carrier's
33 decision, shall be transmitted between the health carrier and the
34 covered person or authorized representative of the covered person by
35 telephone, facsimile, or the most expeditious method available as
36 determined by the health carrier.

37 (d) A health carrier shall make a decision and notify the covered
38 person or authorized representative of the covered person as
39 expeditiously as the medical condition of the covered person requires,

1 but no more than two business days after the request for expedited
2 review is received by the health carrier. If the expedited review is
3 a concurrent review determination, the service shall be continued
4 without liability to the covered person until the covered person or
5 authorized representative of the covered person has been notified of
6 the decision by the health carrier.

7 (e) A health carrier shall provide written confirmation of its
8 decision concerning an expedited review within two working days of
9 providing notification of that decision to the enrollee, if the initial
10 notification was not in writing. The written notification shall
11 contain the provisions required in subsection (3) of this section
12 pertaining to a first level grievance review.

13 (f) In any case where the expedited review process does not resolve
14 a difference of opinion between a health carrier and the covered
15 person, the covered person or authorized representative of the covered
16 person may request a second level grievance review. In conducting the
17 second level grievance review, the health carrier shall adhere to time
18 frames that are reasonable under the circumstances, but in no event to
19 exceed the time frames specified in subsection (4) of this section
20 pertaining to second level grievance review.

21 (11) The Washington state health care authority shall periodically
22 examine grievance procedure accreditation standards of the national
23 committee for quality assurance or other national accreditation
24 organizations for appropriateness and, if deemed appropriate, shall
25 adopt rules exempting a health carrier from the requirements of this
26 section if certified by a national accreditation organization approved
27 by the authority. The powers of the Washington state health care
28 authority set forth in this section are transferred to the office of
29 the insurance commissioner on January 1, 2001.

30 **Sec. 108.** RCW 48.43.055 and 1995 c 265 s 20 are each amended to
31 read as follows:

32 GRIEVANCE PROCEDURE FOR HEALTH CARE PROVIDERS. Each health carrier
33 as defined under RCW 48.43.005 shall file with the commissioner its
34 procedures for review and adjudication of complaints initiated by
35 ~~((covered persons or))~~ a health care provider~~((s))~~. Procedures filed
36 under this section shall provide a fair review for consideration of
37 complaints. Every health carrier shall provide reasonable means
38 whereby ~~((any person))~~ a health care provider aggrieved by actions of

1 the health carrier may be heard in person or by their authorized
2 representative on their written request for review. If the health
3 carrier fails to grant or reject such request within thirty days after
4 it is made, the complaining ((~~person~~)) provider may proceed as if the
5 complaint had been rejected. A complaint that has been rejected by the
6 health carrier may be submitted to nonbinding mediation. Mediation
7 shall be conducted pursuant to mediation rules similar to those of the
8 American arbitration association, the center for public resources, the
9 judicial arbitration and mediation service, RCW 7.70.100, or any other
10 rules of mediation agreed to by the parties.

11 NEW SECTION. **Sec. 109.** GRIEVANCE PROCEDURES--REPEALER. RCW
12 48.46.100 and 1975 1st ex.s. c 290 s 11 are each repealed.

13 NEW SECTION. **Sec. 110.** NETWORK ADEQUACY--INTENT. The legislature
14 declares that it is in the public interest that health carriers
15 utilizing provider networks use reasonable means of assessing that
16 their provider networks are adequate to provide covered services to
17 their enrollees. The legislature finds that empirical assessment of
18 provider network adequacy is in developmental stages, and that rigid,
19 formulaic approaches are unworkable and inhibit innovation and
20 approaches tailored to meet the needs of varying communities and
21 populations. The legislature therefore finds that, given these
22 limitations, an assessment is needed to determine whether network
23 adequacy requirements are needed and, if necessary, whether the type of
24 measures used by current accreditation programs, such as the national
25 committee on quality assurance, meets these needs.

26 NEW SECTION. **Sec. 111.** NETWORK ADEQUACY--STUDY AND RESTRICTION.
27 (1) The department of health, in consultation with the office of the
28 insurance commissioner, the department of social and health services,
29 the health care authority, the health care policy board, consumers,
30 providers, and health carriers, shall review the need for network
31 adequacy requirements. The review must include an evaluation of the
32 approaches used by the national committee on quality assurance and any
33 similar, nationally recognized accreditation programs. The department
34 shall submit its report and recommendations to the health care
35 committees of the legislature by January 1, 1998, and include
36 recommendations on:

1 (a) Whether legislatively determined network adequacy requirements
2 are necessary and advisable and the evidence to support this;

3 (b) If standards are needed, to what extent such standards can be
4 made consistent with the national committee on quality assurance
5 standards, and whether national committee on quality assurance
6 accredited carriers, or carriers accredited by other, nationally
7 recognized accreditation programs, should be exempted from state review
8 and requirements;

9 (c) Whether and how the state could promote uniformity of approach
10 across commercial purchaser requirements and state and federal agency
11 requirements so as to assure adequate consumer access while promoting
12 the most efficient use of public and private health care financial
13 resources;

14 (d) Means to assure that health carriers and health systems
15 maintain the flexibility necessary to responsibly determine the best
16 ways to meet the needs of the populations they serve while controlling
17 the costs of the health care services provided;

18 (e) Which types of health systems and health carriers should be
19 subject to network adequacy requirements, if any; and

20 (f) An objective estimate of the potential costs of such
21 requirements and any recommended oversight functions.

22 (2) No agency may engage in rule making relating to network
23 adequacy until the legislature has reviewed the findings and
24 recommendations of the study and has passed legislation authorizing the
25 department of health or other appropriate agency to engage in rule
26 making in this area in accordance with the policy direction set by the
27 legislature.

28 NEW SECTION. **Sec. 112.** A new section is added to chapter 41.05
29 RCW to read as follows:

30 ACCESS PLAN REQUIREMENTS. (1) Beginning July 1, 1997, health
31 carriers, as defined in RCW 48.43.005, shall develop and update
32 annually an access plan that meets the requirements of this section for
33 each of the health care networks that the carrier offers in this state.
34 The health carrier shall make the access plans available on its
35 business premises and shall provide nonproprietary information to any
36 interested party upon request. The carrier shall prepare an access
37 plan prior to offering a health plan utilizing a substantially

1 different health care network. The plan shall include, at least, the
2 following:

3 (a) The health carrier's network of providers and facilities by
4 license, certification and registration type, and by geographic
5 location;

6 (b) The health carrier's process for monitoring and assuring on an
7 ongoing basis the sufficiency of the provider network to meet the
8 covered health care needs of its enrolled populations; and

9 (c) The health carrier's methods for assessing the health care
10 needs of covered persons and their satisfaction with services.

11 (2) On or before August 1, 1997, each health carrier shall submit
12 its access plan or plans to the Washington state health care authority
13 for purposes of assisting the authority with its report and
14 recommendations on network adequacy standards required under section
15 111 of this act.

16 (3) The Washington state health care authority shall periodically
17 examine accreditation standards of the national committee for quality
18 assurance or other national accreditation organizations for
19 appropriateness and, if deemed appropriate, shall adopt rules exempting
20 a health carrier from the requirements of this section if certified by
21 a national accreditation organization approved by the authority. The
22 powers of the Washington state health care authority set forth in this
23 section are transferred to the office of the insurance commissioner on
24 January 1, 2001.

25 NEW SECTION. **Sec. 113.** A new section is added to chapter 74.09
26 RCW to read as follows:

27 **MEDICAL ASSISTANCE WAIVERS.** To the extent that federal statutes or
28 regulations, or provisions of waivers granted to the department of
29 social and health services by the federal department of health and
30 human services, include standards that differ from the minimums stated
31 in sections 101 through 107, 110, and 112 of this act, those sections
32 do not apply to contracts with health carriers awarded pursuant to RCW
33 74.09.522.

34 **PART II--MARKETPLACE STABILITY**

35 NEW SECTION. **Sec. 201.** **LEGISLATIVE INTENT.** The legislature
36 intends that individuals in the state of Washington have access to

1 affordable individual health plan coverage. The legislature reaffirms
2 its commitment to guaranteed issue and renewability, portability, and
3 limitations on use of preexisting condition exclusions. The
4 legislature also finds that the lack of incentives for individuals to
5 purchase and maintain coverage independent of anticipated need for
6 health care has contributed to soaring health care claims experience in
7 many individual health plans. The legislature therefore intends that
8 refinements be made to the state's individual market reform laws to
9 provide needed incentives and to help assure that more affordable
10 coverage is accessible to Washington residents.

11 **Sec. 202.** RCW 48.43.005 and 1995 c 265 s 4 are each amended to
12 read as follows:

13 DEFINITIONS. Unless otherwise specifically provided, the
14 definitions in this section apply throughout this chapter.

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

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

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

23 (4) "Concurrent review" means utilization review conducted during
24 a patient's hospital stay or course of treatment.

25 (5) "Covered person" or "enrollee" means a person covered by a
26 health plan including an enrollee, subscriber, policyholder,
27 beneficiary of a group plan, or individual covered by any other health
28 plan.

29 ~~((+3+))~~ (6) "Dependent" means, at a minimum, the enrollee's legal
30 spouse and unmarried dependent children who qualify for coverage under
31 the enrollee's health benefit plan.

32 (7) "Eligible employee" means an employee who works on a full-time
33 basis with a normal work week of thirty or more hours. The term
34 includes a self-employed individual, including a sole proprietor, a
35 partner of a partnership, and may include an independent contractor, if
36 the self-employed individual, sole proprietor, partner, or independent
37 contractor is included as an employee under a health benefit plan of a
38 small employer, but does not work less than thirty hours per week and

1 derives at least seventy-five percent of his or her income from a trade
2 or business through which he or she has attempted to earn taxable
3 income and for which he or she has filed the appropriate internal
4 revenue service form. Persons covered under a health benefit plan
5 pursuant to the consolidated omnibus budget reconciliation act of 1986
6 shall not be considered eligible employees for purposes of minimum
7 participation requirements of chapter 265, Laws of 1995.

8 ~~((+4))~~ (8) "Emergency medical condition" means the emergent and
9 acute onset of a symptom or symptoms, including severe pain, that would
10 lead a prudent layperson acting reasonably to believe that a health
11 condition exists that requires immediate medical attention, if failure
12 to provide medical attention would result in serious impairment to
13 bodily functions or serious dysfunction of a bodily organ or part, or
14 would place the person's health in serious jeopardy.

15 (9) "Emergency services" means otherwise covered health care
16 services medically necessary to evaluate and treat an emergency medical
17 condition, provided in a hospital emergency department.

18 (10) "Enrollee point-of-service cost-sharing" means amounts paid to
19 health carriers directly providing services, health care providers, or
20 health care facilities by enrollees and may include copayments,
21 coinsurance, or deductibles.

22 ~~((+5))~~ (11) "Grievance" means a written complaint submitted by or
23 on behalf of a covered person regarding: (a) Denial of payment for
24 medical services or nonprovision of medical services included in the
25 covered person's health benefit plan, or (b) service delivery issues
26 other than denial of payment for medical services or nonprovision of
27 medical services, including dissatisfaction with medical care, waiting
28 time for medical services, provider or staff attitude or demeanor, or
29 dissatisfaction with service provided by the health carrier.

30 (12) "Health care facility" or "facility" means hospices licensed
31 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
32 rural health care facilities as defined in RCW 70.175.020, psychiatric
33 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
34 under chapter 18.51 RCW, community mental health centers licensed under
35 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
36 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
37 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
38 facilities licensed under chapter 70.96A RCW, and home health agencies
39 licensed under chapter 70.127 RCW, and includes such facilities if

1 owned and operated by a political subdivision or instrumentality of the
2 state and such other facilities as required by federal law and
3 implementing regulations.

4 ~~((+6+))~~ (13) "Health care provider" or "provider" means:

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

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

10 ~~((+7+))~~ (14) "Health care service" means that service offered or
11 provided by health care facilities and health care providers relating
12 to the prevention, cure, or treatment of illness, injury, or disease.

13 ~~((+8+))~~ (15) "Health carrier" or "carrier" means a disability
14 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
15 service contractor as defined in RCW 48.44.010, or a health maintenance
16 organization as defined in RCW 48.46.020.

17 ~~((+9+))~~ (16) "Health plan" or "health benefit plan" means any
18 policy, contract, or agreement offered by a health carrier to provide,
19 arrange, reimburse, or pay for health care services except the
20 following:

21 (a) Long-term care insurance governed by chapter 48.84 RCW;

22 (b) Medicare supplemental health insurance governed by chapter
23 48.66 RCW;

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

26 (d) Disability income;

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

30 (f) Workers' compensation coverage;

31 (g) Accident only coverage;

32 (h) Specified disease and hospital confinement indemnity when
33 marketed solely as a supplement to a health plan;

34 (i) Employer-sponsored self-funded health plans; and

35 (j) Dental only and vision only coverage.

36 ~~((+10+))~~ (17) "Basic health plan services" means that schedule of
37 covered health services, including the description of how those
38 benefits are to be administered, that are required to be delivered to
39 an enrollee under the basic health plan, as revised from time to time.

1 (~~(11)~~) (18) "Preexisting condition" means any medical condition,
2 illness, or injury that existed any time prior to the effective date of
3 coverage.

4 (~~(12)~~) (19) "Premium" means all sums charged, received, or
5 deposited by a health carrier as consideration for a health plan or the
6 continuance of a health plan. Any assessment or any "membership,"
7 "policy," "contract," "service," or similar fee or charge made by a
8 health carrier in consideration for a health plan is deemed part of the
9 premium. "Premium" shall not include amounts paid as enrollee point-
10 of-service cost-sharing.

11 (~~(13)~~) (20) "Small employer" means any person, firm, corporation,
12 partnership, association, political subdivision except school
13 districts, or self-employed individual that is actively engaged in
14 business that, on at least fifty percent of its working days during the
15 preceding calendar quarter, employed no more than fifty eligible
16 employees, with a normal work week of thirty or more hours, the
17 majority of whom were employed within this state, and is not formed
18 primarily for purposes of buying health insurance and in which a bona
19 fide employer-employee relationship exists. In determining the number
20 of eligible employees, companies that are affiliated companies, or that
21 are eligible to file a combined tax return for purposes of taxation by
22 this state, shall be considered an employer. Subsequent to the
23 issuance of a health plan to a small employer and for the purpose of
24 determining eligibility, the size of a small employer shall be
25 determined annually. Except as otherwise specifically provided, a
26 small employer shall continue to be considered a small employer until
27 the plan anniversary following the date the small employer no longer
28 meets the requirements of this definition. The term "small employer"
29 includes a self-employed individual or sole proprietor. The term
30 "small employer" also includes a self-employed individual or sole
31 proprietor who derives at least seventy-five percent of his or her
32 income from a trade or business through which the individual or sole
33 proprietor has attempted to earn taxable income and for which he or she
34 has filed the appropriate internal revenue service form 1040, schedule
35 C or F, for the previous taxable year.

36 (~~(14)~~) (21) "Wellness activity" means an explicit program of an
37 activity consistent with department of health guidelines, such as,
38 smoking cessation, injury and accident prevention, reduction of alcohol
39 misuse, appropriate weight reduction, exercise, automobile and

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

4 ~~((15) "Basic health plan" means the plan described under chapter
5 70.47 RCW, as revised from time to time.))~~

6 **Sec. 203.** RCW 48.43.025 and 1995 c 265 s 6 are each amended to
7 read as follows:

8 PREEXISTING CONDITION LIMITATIONS MODIFIED. (1) Except as
9 otherwise specified in RCW 48.43.035:

10 (a) No carrier may reject an individual for health plan coverage
11 based upon preexisting conditions of the individual ((and)).

12 (b) No carrier may deny, exclude, or otherwise limit coverage for
13 an individual's preexisting health conditions; except that a carrier
14 may impose a three-month benefit waiting period for preexisting
15 conditions for which medical advice was given, or for which a health
16 care provider recommended or provided treatment within three months
17 before the effective date of coverage.

18 (c) All health carriers offering any individual health plan to any
19 individual must allow open enrollment to eligible applicants into all
20 individual health plans offered by the carrier during the full month of
21 July of each year. The individual health plans exempt from guaranteed
22 continuity under RCW 48.43.035(4) are exempt from this requirement.
23 All applications for open enrollment coverage must be complete and
24 postmarked to or received by the carrier in the month of July in any
25 year following the effective date of this section. Coverage for these
26 applicants must begin the first day of the next month subject to
27 receipt of timely payment consistent with the terms of the policies.

28 (d) Carriers may limit acceptance of applicants who apply outside
29 of the open enrollment period specified in (c) of this subsection
30 provided all of the following conditions are met:

31 (i) The applicant has not maintained coverage as required in (f) of
32 this subsection;

33 (ii) The applicant is not applying as a newly eligible dependent
34 meeting the requirements of (g) of this subsection; and

35 (iii) The carrier uses uniform health evaluation criteria and
36 practices among all individual health plans it offers.

37 (e) If a carrier refuses to enroll an applicant, it must offer to
38 enroll the applicant in the Washington state health insurance pool in

1 an expeditious manner as determined by the board of directors of the
2 pool. Declination by the applicant to enroll must be done in written
3 form.

4 (f) Carriers may not refuse enrollment based upon health evaluation
5 criteria to otherwise eligible applicants who have been covered either
6 continuously or for any part of the three-month period immediately
7 preceding the date of application for the new individual health plan
8 under a comparable group or individual health benefit plan with
9 substantially similar benefits. For purposes of this subsection, in
10 addition to provisions in RCW 48.43.015, the following publicly
11 administered coverage shall be considered comparable health benefit
12 plans: The basic health plan established by chapter 70.47 RCW; the
13 medical assistance program established by chapter 74.09 RCW; and the
14 Washington state health insurance pool, established by chapter 48.41
15 RCW, as long as the person is continuously enrolled in the pool until
16 the next open enrollment period. If the person is enrolled in the pool
17 for less than three months, she or he will be credited for that period
18 up to three months.

19 (g) Carriers shall accept for enrollment all newly eligible
20 dependents of an enrollee for enrollment onto the enrollee's individual
21 health plan at any time of the year, provided application is made
22 within sixty-three days of eligibility, or such longer time as provided
23 by law or contract.

24 (h) At no time are carriers required to accept for enrollment any
25 individual residing outside the state of Washington, except for
26 qualifying dependents who reside outside the carrier service area.

27 (i) For purposes of this section, "open enrollment" means the
28 annual thirty-one day period during the month of July during which all
29 health carriers offering individual health plan coverage must accept
30 onto individual coverage any state resident within the carrier's
31 service area regardless of health condition who submits an application
32 in accordance with RCW 48.43.035(1).

33 (2) No carrier may avoid the requirements of this section through
34 the creation of a new rate classification or the modification of an
35 existing rate classification. A new or changed rate classification
36 will be deemed an attempt to avoid the provisions of this section if
37 the new or changed classification would substantially discourage
38 applications for coverage from individuals or groups who are higher

1 than average health risks. ((These)) The provisions of this section
2 apply only to individuals who are Washington residents.

3 **Sec. 204.** RCW 48.43.035 and 1995 c 265 s 7 are each amended to
4 read as follows:

5 GUARANTEED ISSUE AND CONTINUITY OF COVERAGE MODIFIED. (1) Except
6 as otherwise specified in RCW 48.43.025, all health carriers shall
7 accept for enrollment any state resident within the carrier's service
8 area and provide or assure the provision of all covered services
9 regardless of age, sex, family structure, ethnicity, race, health
10 condition, geographic location, employment status, socioeconomic
11 status, other condition or situation, or the provisions of RCW
12 49.60.174(2). The insurance commissioner may grant a temporary
13 exemption from this subsection, if, upon application by a health
14 carrier the commissioner finds that the clinical, financial, or
15 administrative capacity to serve existing enrollees will be impaired if
16 a health carrier is required to continue enrollment of additional
17 eligible individuals.

18 (2) Except as provided in subsection ((+5)) (7) of this section,
19 all health plans shall contain or incorporate by endorsement a
20 guarantee of the continuity of coverage of the plan. For the purposes
21 of this section, a plan is "renewed" when it is continued beyond the
22 earliest date upon which, at the carrier's sole option, the plan could
23 have been terminated for other than nonpayment of premium. In the case
24 of group plans, the carrier may consider the group's anniversary date
25 as the renewal date for purposes of complying with the provisions of
26 this section.

27 (3) The guarantee of continuity of coverage required in health
28 plans shall not prevent a carrier from canceling or nonrenewing a
29 health plan for:

30 (a) Nonpayment of premium;

31 (b) Violation of published policies of the carrier approved by the
32 insurance commissioner;

33 (c) Covered persons entitled to become eligible for medicare
34 benefits by reason of age who fail to apply for a medicare supplement
35 plan or medicare cost, risk, or other plan offered by the carrier
36 pursuant to federal laws and regulations;

1 (d) Covered persons who fail to pay any deductible or copayment
2 amount owed to the carrier and not the provider of health care
3 services;

4 (e) Covered persons committing fraudulent acts as to the carrier;

5 (f) Covered persons who materially breach the health plan; ((or))

6 (g) Change or implementation of federal or state laws that no
7 longer permit the continued offering of such coverage; or

8 (h) Cessation of a plan offering in accordance with subsection (5)
9 or (8) of this section.

10 (4) The provisions of this section do not apply in the following
11 cases:

12 (a) A carrier has zero enrollment on a product; ((or))

13 ~~(b) ((A carrier replaces a product and the replacement product is~~
14 ~~provided to all covered persons within that class or line of business,~~
15 ~~includes all of the services covered under the replaced product, and~~
16 ~~does not significantly limit access to the kind of services covered~~
17 ~~under the replaced product. The health plan may also allow~~
18 ~~unrestricted conversion to a fully comparable product; or~~

19 ~~(c))~~ A carrier is withdrawing from a service area or from a
20 segment of its service area because the carrier has demonstrated to the
21 insurance commissioner that the carrier's clinical, financial, or
22 administrative capacity to serve enrollees would be exceeded.

23 (5) A health carrier may discontinue offering or materially modify
24 a particular health plan, only if:

25 (a) The health carrier provides notice to each covered person
26 provided coverage of this type of such discontinuation or modification
27 at least ninety days prior to the date of the discontinuation or
28 modification of coverage;

29 (b) The health carrier offers to each covered person provided
30 coverage of this type the option to purchase any other health plan
31 currently being offered by the health carrier to similar covered
32 persons in the market category and geographic area; and

33 (c) In exercising the option to discontinue or modify a particular
34 health plan and in offering the option of coverage under (b) of this
35 subsection, the health carrier acts uniformly without regard to any
36 health-status related factor of covered persons or persons who may
37 become eligible for coverage.

1 (6) At the time a plan is renewed, a health carrier may modify the
2 health plan coverage so long as such modification is in accordance with
3 subsection (5) of this section.

4 (7) The provisions of this section do not apply to health plans
5 deemed by the insurance commissioner to be unique or limited or have a
6 short-term purpose, after a written request for such classification by
7 the carrier and subsequent written approval by the insurance
8 commissioner.

9 (8) A health carrier may discontinue all health plan coverage in
10 one or more of the following lines of business:

11 (a)(i) Individual; or

12 (ii)(A) Small group (1-50 members); and

13 (B) Large group (51+ members);

14 (b) Only if:

15 (i) The health carrier provides notice to the office of the
16 insurance commissioner and to each person covered by a plan within the
17 line of business of such discontinuation at least one hundred eighty
18 days prior to the expiration of coverage; and

19 (ii) All plans issued or delivered in the state by the health
20 carrier in such line of business are discontinued, and coverage under
21 such plans in such line of business is not renewed; and

22 (iii) The health carrier may not issue any health plan coverage in
23 the line of business and state involved during the five-year period
24 beginning on the date of the discontinuation of the last health plan
25 not so renewed.

26 (9) The portability provisions of RCW 48.43.015 continue to apply
27 to all enrollees whose health insurance coverage is modified or
28 discontinued pursuant to this section.

29 **Sec. 205.** RCW 70.47.060 and 1995 c 266 s 1 and 1995 c 2 s 4 are
30 each reenacted and amended to read as follows:

31 The administrator has the following powers and duties:

32 (1) To design and from time to time revise a schedule of covered
33 basic health care services, including physician services, inpatient and
34 outpatient hospital services, prescription drugs and medications, and
35 other services that may be necessary for basic health care. In
36 addition, the administrator may offer as basic health plan services
37 chemical dependency services, mental health services and organ
38 transplant services; however, no one service or any combination of

1 these three services shall increase the actuarial value of the basic
2 health plan benefits by more than five percent excluding inflation, as
3 determined by the office of financial management. All subsidized and
4 nonsubsidized enrollees in any participating managed health care system
5 under the Washington basic health plan shall be entitled to receive
6 (~~covered basic health care services~~) covered basic health care
7 services in return for premium payments to the plan. The schedule of
8 services shall emphasize proven preventive and primary health care and
9 shall include all services necessary for prenatal, postnatal, and well-
10 child care. However, with respect to coverage for groups of subsidized
11 enrollees who are eligible to receive prenatal and postnatal services
12 through the medical assistance program under chapter 74.09 RCW, the
13 administrator shall not contract for such services except to the extent
14 that such services are necessary over not more than a one-month period
15 in order to maintain continuity of care after diagnosis of pregnancy by
16 the managed care provider. The schedule of services shall also include
17 a separate schedule of basic health care services for children,
18 eighteen years of age and younger, for those subsidized or
19 nonsubsidized enrollees who choose to secure basic coverage through the
20 plan only for their dependent children. In designing and revising the
21 schedule of services, the administrator shall consider the guidelines
22 for assessing health services under the mandated benefits act of 1984,
23 RCW 48.42.080, and such other factors as the administrator deems
24 appropriate.

25 However, with respect to coverage for subsidized enrollees who are
26 eligible to receive prenatal and postnatal services through the medical
27 assistance program under chapter 74.09 RCW, the administrator shall not
28 contract for such services except to the extent that the services are
29 necessary over not more than a one-month period in order to maintain
30 continuity of care after diagnosis of pregnancy by the managed care
31 provider.

32 (2)(a) To design and implement a structure of periodic premiums due
33 the administrator from subsidized enrollees that is based upon gross
34 family income, giving appropriate consideration to family size and the
35 ages of all family members. The enrollment of children shall not
36 require the enrollment of their parent or parents who are eligible for
37 the plan. The structure of periodic premiums shall be applied to
38 subsidized enrollees entering the plan as individuals pursuant to
39 subsection (9) of this section and to the share of the cost of the plan

1 due from subsidized enrollees entering the plan as employees pursuant
2 to subsection (10) of this section.

3 (b) To determine the periodic premiums due the administrator from
4 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
5 shall be in an amount equal to the cost charged by the managed health
6 care system provider to the state for the plan plus the administrative
7 cost of providing the plan to those enrollees and the premium tax under
8 RCW 48.14.0201.

9 (c) An employer or other financial sponsor may, with the prior
10 approval of the administrator, pay the premium, rate, or any other
11 amount on behalf of a subsidized or nonsubsidized enrollee, by
12 arrangement with the enrollee and through a mechanism acceptable to the
13 administrator, but in no case shall the payment made on behalf of the
14 enrollee exceed the total premiums due from the enrollee.

15 (d) To develop, as an offering by all health carriers providing
16 coverage identical to the basic health plan, as configured on January
17 1, 1996, a basic health plan model plan (~~(benefits package)~~) with
18 uniformity in enrollee cost-sharing requirements.

19 (3) To design and implement a structure of enrollee cost sharing
20 due a managed health care system from subsidized and nonsubsidized
21 enrollees. The structure shall discourage inappropriate enrollee
22 utilization of health care services, and may utilize copayments,
23 deductibles, and other cost-sharing mechanisms, but shall not be so
24 costly to enrollees as to constitute a barrier to appropriate
25 utilization of necessary health care services.

26 (4) To limit enrollment of persons who qualify for subsidies so as
27 to prevent an overexpenditure of appropriations for such purposes.
28 Whenever the administrator finds that there is danger of such an
29 overexpenditure, the administrator shall close enrollment until the
30 administrator finds the danger no longer exists.

31 (5) To limit the payment of subsidies to subsidized enrollees, as
32 defined in RCW 70.47.020. The level of subsidy provided to persons who
33 qualify may be based on the lowest cost plans, as defined by the
34 administrator.

35 (6) To adopt a schedule for the orderly development of the delivery
36 of services and availability of the plan to residents of the state,
37 subject to the limitations contained in RCW 70.47.080 or any act
38 appropriating funds for the plan.

1 (7) To solicit and accept applications from managed health care
2 systems, as defined in this chapter, for inclusion as eligible basic
3 health care providers under the plan. The administrator shall endeavor
4 to assure that covered basic health care services are available to any
5 enrollee of the plan from among a selection of two or more
6 participating managed health care systems. In adopting any rules or
7 procedures applicable to managed health care systems and in its
8 dealings with such systems, the administrator shall consider and make
9 suitable allowance for the need for health care services and the
10 differences in local availability of health care resources, along with
11 other resources, within and among the several areas of the state.
12 Contracts with participating managed health care systems shall ensure
13 that basic health plan enrollees who become eligible for medical
14 assistance may, at their option, continue to receive services from
15 their existing providers within the managed health care system if such
16 providers have entered into provider agreements with the department of
17 social and health services.

18 (8) To receive periodic premiums from or on behalf of subsidized
19 and nonsubsidized enrollees, deposit them in the basic health plan
20 operating account, keep records of enrollee status, and authorize
21 periodic payments to managed health care systems on the basis of the
22 number of enrollees participating in the respective managed health care
23 systems.

24 (9) To accept applications from individuals residing in areas
25 served by the plan, on behalf of themselves and their spouses and
26 dependent children, for enrollment in the Washington basic health plan
27 as subsidized or nonsubsidized enrollees, to establish appropriate
28 minimum-enrollment periods for enrollees as may be necessary, and to
29 determine, upon application and on a reasonable schedule defined by the
30 authority, or at the request of any enrollee, eligibility due to
31 current gross family income for sliding scale premiums. No subsidy
32 may be paid with respect to any enrollee whose current gross family
33 income exceeds twice the federal poverty level or, subject to RCW
34 70.47.110, who is a recipient of medical assistance or medical care
35 services under chapter 74.09 RCW. If, as a result of an eligibility
36 review, the administrator determines that a subsidized enrollee's
37 income exceeds twice the federal poverty level and that the enrollee
38 knowingly failed to inform the plan of such increase in income, the
39 administrator may bill the enrollee for the subsidy paid on the

1 enrollee's behalf during the period of time that the enrollee's income
2 exceeded twice the federal poverty level. If a number of enrollees
3 drop their enrollment for no apparent good cause, the administrator may
4 establish appropriate rules or requirements that are applicable to such
5 individuals before they will be allowed to reenroll in the plan.

6 (10) To accept applications from business owners on behalf of
7 themselves and their employees, spouses, and dependent children, as
8 subsidized or nonsubsidized enrollees, who reside in an area served by
9 the plan. The administrator may require all or the substantial
10 majority of the eligible employees of such businesses to enroll in the
11 plan and establish those procedures necessary to facilitate the orderly
12 enrollment of groups in the plan and into a managed health care system.
13 The administrator may require that a business owner pay at least an
14 amount equal to what the employee pays after the state pays its portion
15 of the subsidized premium cost of the plan on behalf of each employee
16 enrolled in the plan. Enrollment is limited to those not eligible for
17 medicare who wish to enroll in the plan and choose to obtain the basic
18 health care coverage and services from a managed care system
19 participating in the plan. The administrator shall adjust the amount
20 determined to be due on behalf of or from all such enrollees whenever
21 the amount negotiated by the administrator with the participating
22 managed health care system or systems is modified or the administrative
23 cost of providing the plan to such enrollees changes.

24 (11) To determine the rate to be paid to each participating managed
25 health care system in return for the provision of covered basic health
26 care services to enrollees in the system. Although the schedule of
27 covered basic health care services will be the same for similar
28 enrollees, the rates negotiated with participating managed health care
29 systems may vary among the systems. In negotiating rates with
30 participating systems, the administrator shall consider the
31 characteristics of the populations served by the respective systems,
32 economic circumstances of the local area, the need to conserve the
33 resources of the basic health plan trust account, and other factors the
34 administrator finds relevant.

35 (12) To monitor the provision of covered services to enrollees by
36 participating managed health care systems in order to assure enrollee
37 access to good quality basic health care, to require periodic data
38 reports concerning the utilization of health care services rendered to
39 enrollees in order to provide adequate information for evaluation, and

1 to inspect the books and records of participating managed health care
2 systems to assure compliance with the purposes of this chapter. In
3 requiring reports from participating managed health care systems,
4 including data on services rendered enrollees, the administrator shall
5 endeavor to minimize costs, both to the managed health care systems and
6 to the plan. The administrator shall coordinate any such reporting
7 requirements with other state agencies, such as the insurance
8 commissioner and the department of health, to minimize duplication of
9 effort.

10 (13) To evaluate the effects this chapter has on private employer-
11 based health care coverage and to take appropriate measures consistent
12 with state and federal statutes that will discourage the reduction of
13 such coverage in the state.

14 (14) To develop a program of proven preventive health measures and
15 to integrate it into the plan wherever possible and consistent with
16 this chapter.

17 (15) To provide, consistent with available funding, assistance for
18 rural residents, underserved populations, and persons of color.

19 **Sec. 206.** RCW 48.20.028 and 1995 c 265 s 13 are each amended to
20 read as follows:

21 TENURE DISCOUNTS--INDIVIDUAL DISABILITY COVERAGE. (1)(a) An
22 insurer offering any health benefit plan to any individual shall offer
23 and actively market to all individuals a health benefit plan providing
24 benefits identical to the schedule of covered health ((services))
25 benefits that are required to be delivered to an individual enrolled in
26 the basic health plan subject to RCW 48.43.035. Nothing in this
27 subsection shall preclude an insurer from offering, or an individual
28 from purchasing, other health benefit plans that may have more or less
29 comprehensive benefits than the basic health plan, provided such plans
30 are in accordance with this chapter. An insurer offering a health
31 benefit plan that does not include benefits provided in the basic
32 health plan shall clearly disclose these differences to the individual
33 in a brochure approved by the commissioner.

34 (b) A health benefit plan shall provide coverage for hospital
35 expenses and services rendered by a physician licensed under chapter
36 18.57 or 18.71 RCW but is not subject to the requirements of RCW
37 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411,
38 48.20.412, 48.20.416, and 48.20.420 if the health benefit plan is the

1 mandatory offering under (a) of this subsection that provides benefits
2 identical to the basic health plan, to the extent these requirements
3 differ from the basic health plan.

4 (2) Premiums for health benefit plans for individuals shall be
5 calculated using the adjusted community rating method that spreads
6 financial risk across the carrier's entire individual product
7 population. All such rates shall conform to the following:

8 (a) The insurer shall develop its rates based on an adjusted
9 community rate and may only vary the adjusted community rate for:

- 10 (i) Geographic area;
- 11 (ii) Family size;
- 12 (iii) Age; (~~and~~)
- 13 (iv) Tenure discounts; and
- 14 (v) Wellness activities.

15 (b) The adjustment for age in (a)(iii) of this subsection may not
16 use age brackets smaller than five-year increments which shall begin
17 with age twenty and end with age sixty-five. Individuals under the age
18 of twenty shall be treated as those age twenty.

19 (c) The insurer shall be permitted to develop separate rates for
20 individuals age sixty-five or older for coverage for which medicare is
21 the primary payer and coverage for which medicare is not the primary
22 payer. Both rates shall be subject to the requirements of this
23 subsection.

24 (d) The permitted rates for any age group shall be no more than
25 four hundred twenty-five percent of the lowest rate for all age groups
26 on January 1, 1996, four hundred percent on January 1, 1997, and three
27 hundred seventy-five percent on January 1, 2000, and thereafter.

28 (e) A discount for wellness activities shall be permitted to
29 reflect actuarially justified differences in utilization or cost
30 attributed to such programs not to exceed twenty percent.

31 (f) The rate charged for a health benefit plan offered under this
32 section may not be adjusted more frequently than annually except that
33 the premium may be changed to reflect:

- 34 (i) Changes to the family composition;
- 35 (ii) Changes to the health benefit plan requested by the
36 individual; or
- 37 (iii) Changes in government requirements affecting the health
38 benefit plan.

1 (g) For the purposes of this section, a health benefit plan that
2 contains a restricted network provision shall not be considered similar
3 coverage to a health benefit plan that does not contain such a
4 provision, provided that the restrictions of benefits to network
5 providers result in substantial differences in claims costs. This
6 subsection does not restrict or enhance the portability of benefits as
7 provided in RCW 48.43.015.

8 (h) A tenure discount for continuous enrollment in the health plan
9 of two years or more may be offered, not to exceed ten percent.

10 (3) Adjusted community rates established under this section shall
11 pool the medical experience of all individuals purchasing coverage, and
12 shall not be required to be pooled with the medical experience of
13 health benefit plans offered to small employers under RCW 48.21.045.

14 (4) As used in this section, "health benefit plan," "basic health
15 plan," "adjusted community rate," and "wellness activities" mean the
16 same as defined in RCW 48.43.005.

17 **Sec. 207.** RCW 48.44.022 and 1995 c 265 s 15 are each amended to
18 read as follows:

19 TENURE DISCOUNTS--HEALTH CARE SERVICE CONTRACTORS. (1)(a) A health
20 care service contractor offering any health benefit plan to any
21 individual shall offer and actively market to all individuals a health
22 benefit plan providing benefits identical to the schedule of covered
23 health (~~(services)~~) benefits that are required to be delivered to an
24 individual enrolled in the basic health plan, subject to the provisions
25 in RCW 48.43.035. Nothing in this subsection shall preclude a
26 contractor from offering, or an individual from purchasing, other
27 health benefit plans that may have more or less comprehensive benefits
28 than the basic health plan, provided such plans are in accordance with
29 this chapter. A contractor offering a health benefit plan that does
30 not include benefits provided in the basic health plan shall clearly
31 disclose these differences to the individual in a brochure approved by
32 the commissioner.

33 (b) A health benefit plan shall provide coverage for hospital
34 expenses and services rendered by a physician licensed under chapter
35 18.57 or 18.71 RCW but is not subject to the requirements of RCW
36 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310,
37 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344,
38 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if the health

1 benefit plan is the mandatory offering under (a) of this subsection
2 that provides benefits identical to the basic health plan, to the
3 extent these requirements differ from the basic health plan.

4 (2) Premium rates for health benefit plans for individuals shall be
5 subject to the following provisions:

6 (a) The health care service contractor shall develop its rates
7 based on an adjusted community rate and may only vary the adjusted
8 community rate for:

- 9 (i) Geographic area;
- 10 (ii) Family size;
- 11 (iii) Age; (~~and~~)
- 12 (iv) Tenure discounts; and
- 13 (v) Wellness activities.

14 (b) The adjustment for age in (a)(iii) of this subsection may not
15 use age brackets smaller than five-year increments which shall begin
16 with age twenty and end with age sixty-five. Individuals under the age
17 of twenty shall be treated as those age twenty.

18 (c) The health care service contractor shall be permitted to
19 develop separate rates for individuals age sixty-five or older for
20 coverage for which medicare is the primary payer and coverage for which
21 medicare is not the primary payer. Both rates shall be subject to the
22 requirements of this subsection.

23 (d) The permitted rates for any age group shall be no more than
24 four hundred twenty-five percent of the lowest rate for all age groups
25 on January 1, 1996, four hundred percent on January 1, 1997, and three
26 hundred seventy-five percent on January 1, 2000, and thereafter.

27 (e) A discount for wellness activities shall be permitted to
28 reflect actuarially justified differences in utilization or cost
29 attributed to such programs not to exceed twenty percent.

30 (f) The rate charged for a health benefit plan offered under this
31 section may not be adjusted more frequently than annually except that
32 the premium may be changed to reflect:

- 33 (i) Changes to the family composition;
- 34 (ii) Changes to the health benefit plan requested by the
35 individual; or
- 36 (iii) Changes in government requirements affecting the health
37 benefit plan.

38 (g) For the purposes of this section, a health benefit plan that
39 contains a restricted network provision shall not be considered similar

1 coverage to a health benefit plan that does not contain such a
2 provision, provided that the restrictions of benefits to network
3 providers result in substantial differences in claims costs. This
4 subsection does not restrict or enhance the portability of benefits as
5 provided in RCW 48.43.015.

6 (h) A tenure discount for continuous enrollment in the health plan
7 of two years or more may be offered, not to exceed ten percent.

8 (3) Adjusted community rates established under this section shall
9 pool the medical experience of all individuals purchasing coverage, and
10 shall not be required to be pooled with the medical experience of
11 health benefit plans offered to small employers under RCW 48.44.023.

12 (4) As used in this section and RCW 48.44.023 "health benefit
13 plan," "small employer," "basic health plan," "adjusted community
14 rates," and "wellness activities" mean the same as defined in RCW
15 48.43.005.

16 **Sec. 208.** RCW 48.46.064 and 1995 c 265 s 17 are each amended to
17 read as follows:

18 TENURE DISCOUNTS--HEALTH MAINTENANCE ORGANIZATIONS. (1)(a) A
19 health maintenance organization offering any health benefit plan to any
20 individual shall offer and actively market to all individuals a health
21 benefit plan providing benefits identical to the schedule of covered
22 health (~~(services)~~) benefits that are required to be delivered to an
23 individual enrolled in the basic health plan, subject to the provisions
24 in RCW 48.43.035. Nothing in this subsection shall preclude a health
25 maintenance organization from offering, or an individual from
26 purchasing, other health benefit plans that may have more or less
27 comprehensive benefits than the basic health plan, provided such plans
28 are in accordance with this chapter. A health maintenance organization
29 offering a health benefit plan that does not include benefits provided
30 in the basic health plan shall clearly disclose these differences to
31 the individual in a brochure approved by the commissioner.

32 (b) A health benefit plan shall provide coverage for hospital
33 expenses and services rendered by a physician licensed under chapter
34 18.57 or 18.71 RCW but is not subject to the requirements of RCW
35 48.46.275, (~~(48.26.280-[48.46.280])~~) 48.46.280, 48.46.285, 48.46.290,
36 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510,
37 48.46.520, and 48.46.530 if the health benefit plan is the mandatory
38 offering under (a) of this subsection that provides benefits identical

1 to the basic health plan, to the extent these requirements differ from
2 the basic health plan.

3 (2) Premium rates for health benefit plans for individuals shall be
4 subject to the following provisions:

5 (a) The health maintenance organization shall develop its rates
6 based on an adjusted community rate and may only vary the adjusted
7 community rate for:

8 (i) Geographic area;

9 (ii) Family size;

10 (iii) Age; (~~and~~)

11 (iv) Tenure discounts; and

12 (v) Wellness activities.

13 (b) The adjustment for age in (a)(iii) of this subsection may not
14 use age brackets smaller than five-year increments which shall begin
15 with age twenty and end with age sixty-five. Individuals under the age
16 of twenty shall be treated as those age twenty.

17 (c) The health maintenance organization shall be permitted to
18 develop separate rates for individuals age sixty-five or older for
19 coverage for which medicare is the primary payer and coverage for which
20 medicare is not the primary payer. Both rates shall be subject to the
21 requirements of this subsection.

22 (d) The permitted rates for any age group shall be no more than
23 four hundred twenty-five percent of the lowest rate for all age groups
24 on January 1, 1996, four hundred percent on January 1, 1997, and three
25 hundred seventy-five percent on January 1, 2000, and thereafter.

26 (e) A discount for wellness activities shall be permitted to
27 reflect actuarially justified differences in utilization or cost
28 attributed to such programs not to exceed twenty percent.

29 (f) The rate charged for a health benefit plan offered under this
30 section may not be adjusted more frequently than annually except that
31 the premium may be changed to reflect:

32 (i) Changes to the family composition;

33 (ii) Changes to the health benefit plan requested by the
34 individual; or

35 (iii) Changes in government requirements affecting the health
36 benefit plan.

37 (g) For the purposes of this section, a health benefit plan that
38 contains a restricted network provision shall not be considered similar
39 coverage to a health benefit plan that does not contain such a

1 provision, provided that the restrictions of benefits to network
2 providers result in substantial differences in claims costs. This
3 subsection does not restrict or enhance the portability of benefits as
4 provided in RCW 48.43.015.

5 (h) A tenure discount for continuous enrollment in the health plan
6 of two years or more may be offered, not to exceed ten percent.

7 (3) Adjusted community rates established under this section shall
8 pool the medical experience of all individuals purchasing coverage, and
9 shall not be required to be pooled with the medical experience of
10 health benefit plans offered to small employers under RCW 48.46.066.

11 (4) As used in this section and RCW 48.46.066, "health benefit
12 plan," "basic health plan," "adjusted community rate," "small
13 employer," and "wellness activities" mean the same as defined in RCW
14 48.43.005.

15 **Sec. 209.** RCW 48.41.030 and 1989 c 121 s 1 are each amended to
16 read as follows:

17 HEALTH INSURANCE POOL--DEFINITIONS. As used in this chapter, the
18 following terms have the meaning indicated, unless the context requires
19 otherwise:

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

26 (2) "Administrator" means the entity chosen by the board to
27 administer the pool under RCW 48.41.080.

28 (3) "Board" means the board of directors of the pool.

29 (4) "Commissioner" means the insurance commissioner.

30 (5) "Health care facility" has the same meaning as in RCW
31 70.38.025.

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

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

37 (8) "Health ((insurance)) coverage" means any group or individual
38 disability insurance policy, health care service contract, and health

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

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

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

30 ~~((11))~~ "Medical assistance" means coverage under Title XIX of the
31 federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and chapter
32 74.09 RCW.

33 ~~((12))~~ (11) "Medicare" means coverage under Title XVIII of the
34 Social Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

35 ~~((13))~~ (12) "Member" means any commercial insurer which provides
36 disability insurance, any health care service contractor, and any
37 health maintenance organization licensed under Title 48 RCW. "Member"
38 shall also mean, as soon as authorized by federal law, employers and
39 other entities, including a self-funding entity and employee welfare

1 benefit plans that provide health plan benefits in this state on or
2 after May 18, 1987. "Member" does not include any insurer, health care
3 service contractor, or health maintenance organization whose products
4 are exclusively dental products or those products excluded from the
5 definition of "health ((insurance)) coverage" set forth in subsection
6 (8) of this section.

7 (13) "Network provider" means a health care provider who has
8 contracted in writing with the pool administrator to accept payment
9 from and to look solely to the pool according to the terms of the pool
10 health plans.

11 (14) "Plan of operation" means the pool, including articles, by-
12 laws, and operating rules, adopted by the board pursuant to RCW
13 48.41.050.

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

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

20 ~~((16))~~ (17) "Substantially equivalent health plan" means a
21 "health plan" as defined in subsection (9) of this section which, in
22 the judgment of the board or the administrator, offers persons
23 including dependents or spouses covered or making application to be
24 covered by this pool an overall level of benefits deemed approximately
25 equivalent to the minimum benefits available under this pool.

26 **Sec. 210.** RCW 48.41.060 and 1989 c 121 s 3 are each amended to
27 read as follows:

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

34 (1) Enter into contracts as are necessary or proper to carry out
35 the provisions and purposes of this chapter including the authority,
36 with the approval of the commissioner, to enter into contracts with
37 similar pools of other states for the joint performance of common

1 administrative functions, or with persons or other organizations for
2 the performance of administrative functions;

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

6 (3) Establish appropriate rates, rate schedules, rate adjustments,
7 expense allowances, agent referral fees, claim reserve formulas and any
8 other actuarial functions appropriate to the operation of the pool.
9 Rates shall not be unreasonable in relation to the coverage provided,
10 the risk experience, and expenses of providing the coverage. Rates and
11 rate schedules may be adjusted for appropriate risk factors such as age
12 and area variation in claim costs and shall take into consideration
13 appropriate risk factors in accordance with established actuarial
14 underwriting practices consistent with Washington state individual plan
15 rating requirements under RCW 48.20.028, 48.44.022, and 48.46.064;

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

21 (5) Issue policies of ((insurance)) health coverage in accordance
22 with the requirements of this chapter;

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

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

31 **Sec. 211.** RCW 48.41.080 and 1989 c 121 s 5 are each amended to
32 read as follows:

33 HEALTH INSURANCE POOL--ADMINISTRATOR'S POWER MODIFIED. The board
34 shall select an administrator from the membership of the pool whether
35 domiciled in this state or another state through a competitive bidding
36 process to administer the pool.

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

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

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

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

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

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

16 (3) The administrator shall perform such duties as may be assigned
17 by the board including:

18 (a) All eligibility and administrative claim payment functions
19 relating to the pool;

20 (b) Establishing a premium billing procedure for collection of
21 premiums from ((~~insured~~) covered persons. Billings shall be made on
22 a periodic basis as determined by the board, which shall not be more
23 frequent than a monthly billing;

24 (c) Performing all necessary functions to assure timely payment of
25 benefits to covered persons under the pool including:

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

29 (ii) Taking steps necessary to offer and administer managed care
30 benefit plans; and

31 (iii) Evaluating the eligibility of each claim for payment by the
32 pool;

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

36 (e) Following the close of each accounting year, determination of
37 net paid and earned premiums, the expense of administration, and the
38 paid and incurred losses for the year and reporting this information to

1 the board and the commissioner on a form as prescribed by the
2 commissioner.

3 (4) The administrator shall be paid as provided in the contract
4 between the board and the administrator for its expenses incurred in
5 the performance of its services.

6 **Sec. 212.** RCW 48.41.110 and 1987 c 431 s 11 are each amended to
7 read as follows:

8 HEALTH INSURANCE POOL--BENEFITS MODIFIED. (1) The pool is
9 authorized to offer one or more managed care plans of coverage. Such
10 plans may, but are not required to, include point of service features
11 that permit participants to receive in-network benefits or out-of-
12 network benefits subject to differential cost shares. Covered persons
13 enrolled in the pool on January 1, 1997, may continue coverage under
14 the pool plan in which they are enrolled on that date. However, the
15 pool may incorporate managed care features into such existing plans.

16 (2) The administrator shall prepare a brochure outlining the
17 benefits and exclusions of the pool policy in plain language. After
18 approval by the board of directors, such brochure shall be made
19 reasonably available to participants or potential participants. The
20 health insurance policy issued by the pool shall pay only usual,
21 customary, and reasonable charges for medically necessary eligible
22 health care services rendered or furnished for the diagnosis or
23 treatment of illnesses, injuries, and conditions which are not
24 otherwise limited or excluded. Eligible expenses are the usual,
25 customary, and reasonable charges for the health care services and
26 items for which benefits are extended under the pool policy. Such
27 benefits shall at minimum include, but not be limited to, the following
28 services or related items:

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

36 (b) Professional services including surgery for the treatment of
37 injuries, illnesses, or conditions, other than dental, which are
38 rendered by a health care provider, or at the direction of a health

1 care provider, by a staff of registered or licensed practical nurses,
2 or other health care providers;

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

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

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

13 (f) Services of a home health agency;

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

16 (h) Oxygen;

17 (i) Anesthesia services;

18 (j) Prostheses, other than dental;

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

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

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

29 (n) Maternity care services, as provided in the managed care plan
30 to be designed by the pool board of directors;

31 (o) Services of a physical therapist and services of a speech
32 therapist;

33 ((+o)) (p) Hospice services;

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

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

1 (~~(2)~~) (3) The board shall design and employ cost containment
2 measures and requirements such as, but not limited to, care
3 coordination, provider network limitations, preadmission certification,
4 and concurrent inpatient review which may make the pool more cost-
5 effective.

6 (~~(3)~~) (4) The pool benefit policy may contain benefit
7 limitations, exceptions, and (~~reductions~~) cost shares such as
8 copayments, coinsurance, and deductibles that are consistent with
9 managed care products, except that differential cost shares may be
10 adopted by the board for nonnetwork providers under point of service
11 plans. The pool benefit policy cost shares and limitations must be
12 consistent with those that are generally included in health
13 (~~insurance~~) plans (~~and are~~) approved by the insurance commissioner;
14 however, no limitation, exception, or reduction may be (~~approved~~)
15 used that would exclude coverage for any disease, illness, or injury.

16 (5) The pool may not reject an individual for health plan coverage
17 based upon preexisting conditions of the individual or deny, exclude,
18 or otherwise limit coverage for an individual's preexisting health
19 conditions; except that it may impose a three-month benefit waiting
20 period for preexisting conditions for which medical advice was given,
21 or for which a health care provider recommended or provided treatment,
22 within three months before the effective date of coverage. The pool
23 may not avoid the requirements of this section through the creation of
24 a new rate classification or the modification of an existing rate
25 classification.

26 **Sec. 213.** RCW 48.41.200 and 1987 c 431 s 20 are each amended to
27 read as follows:

28 HEALTH INSURANCE POOL--RATE MODIFIED. The pool shall determine the
29 standard risk rate by calculating the average group standard rate for
30 groups comprised of up to (~~ten~~) fifty persons charged by the five
31 largest members offering coverages in the state comparable to the pool
32 coverage. In the event five members do not offer comparable coverage,
33 the standard risk rate shall be established using reasonable actuarial
34 techniques and shall reflect anticipated experience and expenses for
35 such coverage. Maximum rates for pool coverage shall be one hundred
36 fifty percent for the indemnity health plan and one hundred twenty-five
37 percent for managed care plans of the rates established as applicable
38 for group standard risks in groups comprised of up to (~~ten~~) fifty

1 persons(~~(. All rates and rate schedules shall be submitted to the~~
2 ~~commissioner for approval)~~).

3 **Sec. 214.** RCW 48.41.130 and 1987 c 431 s 13 are each amended to
4 read as follows:

5 HEALTH INSURANCE POOL--SUBSTANTIAL EQUIVALENT CLARIFIED. All
6 policy forms issued by the pool shall conform in substance to prototype
7 forms developed by the pool, and shall in all other respects conform to
8 the requirements of this chapter, and shall be filed with and approved
9 by the commissioner before they are issued. The pool shall not issue
10 a pool policy to any individual who, on the effective date of the
11 coverage applied for, already has or would have coverage substantially
12 equivalent to a pool policy as an insured or covered dependent, or who
13 would be eligible for such coverage if he or she elected to obtain it
14 at a lesser premium rate. However, coverage provided by the basic
15 health plan, as established pursuant to chapter 70.47 RCW, shall not be
16 deemed substantially equivalent for the purposes of this section.

17 NEW SECTION. **Sec. 215.** A new section is added to chapter 48.44
18 RCW to read as follows:

19 LOSS RATIOS--HEALTH CARE SERVICE CONTRACTORS. (1) For purposes of
20 RCW 48.44.020(2)(d), benefits in a contract shall be deemed reasonable
21 in relation to the amount charged provided that the anticipated loss
22 ratio is at least:

23 (a) Sixty-five percent for individual subscriber contract forms;

24 (b) Seventy percent for franchise plan contract forms;

25 (c) Eighty percent for group contract forms other than small group
26 contract forms; and

27 (d) Seventy-five percent for small group contract forms.

28 (2) With the approval of the commissioner, contract, rider, and
29 endorsement forms that provide substantially similar coverage may be
30 combined for the purpose of determining the anticipated loss ratio.

31 (3) A health care service contractor may charge the rate for
32 prepayment of health care services in any contract identified in RCW
33 48.44.020(1) upon filing of the rate with the commissioner. If the
34 commissioner disapproves the rate, the commissioner shall explain in
35 writing the specific reasons for the disapproval. A health care
36 service contractor may continue to charge such rate pending a final
37 order in any hearing held under chapters 48.04 and 34.05 RCW, or if

1 applicable, pending a final order in any appeal. Any amount charged
2 that is determined in a final order on appeal to be unreasonable in
3 relation to the benefits provided is subject to refund.

4 (4) For the purposes of this section:

5 (a) "Anticipated loss ratio" means the ratio of all anticipated
6 claims or costs for the delivery of covered health care services
7 including incurred but not reported claims and costs and medical
8 management costs to premium minus any applicable taxes.

9 (b) "Small group contract form" means a form offered to a small
10 employer as defined in RCW 48.43.005(13).

11 NEW SECTION. **Sec. 216.** A new section is added to chapter 48.46
12 RCW to read as follows:

13 LOSS RATIOS--HEALTH MAINTENANCE ORGANIZATIONS. (1) For purposes of
14 RCW 48.46.060(3)(d), benefits shall be deemed reasonable in relation to
15 the amount charged provided that the anticipated loss ratio is at
16 least:

17 (a) Sixty-five percent for individual subscriber contract forms;

18 (b) Seventy percent for franchise plan contract forms;

19 (c) Eighty percent for group contract forms other than small group
20 contract forms; and

21 (d) Seventy-five percent for small group contract forms.

22 (2) With the approval of the commissioner, contract, rider, and
23 endorsement forms that provide substantially similar coverage may be
24 combined for the purpose of determining the anticipated loss ratio.

25 (3) A health maintenance organization may charge the rate for
26 prepayment of health care services in any contract identified in RCW
27 48.46.060(1) upon filing of the rate with the commissioner. If the
28 commissioner disapproves the rate, the commissioner shall explain in
29 writing the specific reasons for the disapproval. A health maintenance
30 organization may continue to charge such rate pending a final order in
31 any hearing held under chapters 48.04 and 34.05 RCW, or if applicable,
32 pending a final order in any appeal. Any amount charged that is
33 determined in a final order on appeal to be unreasonable in relation to
34 the benefits provided is subject to refund.

35 (4) For the purposes of this section:

36 (a) "Anticipated loss ratio" means the ratio of all anticipated
37 claims or costs for the delivery of covered health care services

1 including incurred but not reported claims and costs and medical
2 management costs to premium minus any applicable taxes.

3 (b) "Small group contract form" means a form offered to a small
4 employer as defined in RCW 48.43.005(13).

5 NEW SECTION. **Sec. 217.** A new section is added to chapter 48.21
6 RCW to read as follows:

7 LOSS RATIOS--GROUPS' DISABILITY COVERAGE. The following standards
8 and requirements apply to group and blanket disability insurance policy
9 forms and manual rates:

10 (1) Specified disease group insurance shall generate at least a
11 seventy-five percent loss ratio regardless of the size of the group.

12 (2) Group disability insurance, other than specified disease
13 insurance, as to which the insureds pay all or substantially all of the
14 premium shall generate loss ratios no lower than those set forth in the
15 following table.

16 Number of Certificate Holders	Minimum Overall
17 at Issue, Renewal, or Rerating	Loss Ratio
18 9 or less	60%
19 10 to 24	65%
20 25 to 49	70%
21 50 to 99	75%
22 100 or more	80%

23 (3) Group disability policy forms, other than for specified disease
24 insurance, for issue to single employers insuring less than one hundred
25 lives shall generate loss ratios no lower than those set forth in
26 subsection (2) of this section for groups of the same size.

27 (4) The calculating period may vary with the benefit and premium
28 provisions. The company may be required to demonstrate the
29 reasonableness of the calculating period chosen by the actuary
30 responsible for the premium calculations.

31 (5) A request for a rate increase submitted at the end of the
32 calculating period shall include a comparison of the actual to the
33 expected loss ratios and shall employ any accumulation of reserves in
34 the determination of rates for the selected calculating period and
35 account for the maintenance of such reserves for future needs. The
36 request for the rate increase shall be further documented by the
37 expected loss ratio for the new calculating period.

1 (6) A request for a rate increase submitted during the calculating
2 period shall include a comparison of the actual to the expected loss
3 ratios, a demonstration of any contributions to or support from the
4 reserves, and shall account for the maintenance of such reserves for
5 future needs. If the experience justifies a premium increase it shall
6 be deemed that the calculating period has prematurely been brought to
7 an end. The rate increase shall further be documented by the expected
8 loss ratio for the next calculating period.

9 (7) The commissioner may approve a series of two or three smaller
10 rate increases in lieu of one larger increase. These should be
11 calculated to reduce the lapses and antiselection that often result
12 from large rate increases. A demonstration of such calculations,
13 whether for a single rate increase or a series of smaller rate
14 increases, satisfactory to the commissioner, shall be attached to the
15 filing.

16 (8) Companies shall review their experience periodically and file
17 appropriate rate revisions in a timely manner to reduce the necessity
18 of later filing of exceptionally large rate increases.

19 (9) The definitions in section 220 of this act and the provisions
20 in section 219 of this act apply to this section.

21 NEW SECTION. **Sec. 218.** A new section is added to chapter 48.20
22 RCW to read as follows:

23 LOSS RATIOS--INDIVIDUAL DISABILITY COVERAGE. The following
24 standards and requirements apply to individual disability insurance
25 forms:

26 (1) The overall loss ratio shall be deemed reasonable in relation
27 to the premiums if the overall loss ratio is at least sixty percent
28 over a calculating period chosen by the insurer and satisfactory to the
29 commissioner.

30 (2) The calculating period may vary with the benefit and renewal
31 provisions. The company may be required to demonstrate the
32 reasonableness of the calculating period chosen by the actuary
33 responsible for the premium calculations. A brief explanation of the
34 selected calculating period shall accompany the filing.

35 (3) Policy forms, the benefits of which are particularly exposed to
36 the effects of inflation and whose premium income may be particularly
37 vulnerable to an eroding persistency and other similar forces, shall
38 use a relatively short calculating period reflecting the uncertainties

1 of estimating the risks involved. Policy forms based on more
2 dependable statistics may employ a longer calculating period. The
3 calculating period may be the lifetime of the contract for guaranteed
4 renewable and noncancellable policy forms if such forms provide
5 benefits that are supported by reliable statistics and that are
6 protected from inflationary or eroding forces by such factors as fixed
7 dollar coverages, inside benefit limits, or the inherent nature of the
8 benefits. The calculating period may be as short as one year for
9 coverages that are based on statistics of minimal reliability or that
10 are highly exposed to inflation.

11 (4) A request for a rate increase to be effective at the end of the
12 calculating period shall include a comparison of the actual to the
13 expected loss ratios, shall employ any accumulation of reserves in the
14 determination of rates for the new calculating period, and shall
15 account for the maintenance of such reserves for future needs. The
16 request for the rate increase shall be further documented by the
17 expected loss ratio for the new calculating period.

18 (5) A request for a rate increase submitted during the calculating
19 period shall include a comparison of the actual to the expected loss
20 ratios, a demonstration of any contributions to and support from the
21 reserves, and shall account for the maintenance of such reserves for
22 future needs. If the experience justifies a premium increase it shall
23 be deemed that the calculating period has prematurely been brought to
24 an end. The rate increase shall further be documented by the expected
25 loss ratio for the next calculating period.

26 (6) The commissioner may approve a series of two or three smaller
27 rate increases in lieu of one large increase. These should be
28 calculated to reduce lapses and anti-selection that often result from
29 large rate increases. A demonstration of such calculations, whether
30 for a single rate increase or for a series of smaller rate increases,
31 satisfactory to the commissioner, shall be attached to the filing.

32 (7) Companies shall review their experience periodically and file
33 appropriate rate revisions in a timely manner to reduce the necessity
34 of later filing of exceptionally large rate increases.

35 NEW SECTION. **Sec. 219.** A new section is added to chapter 48.20
36 RCW to read as follows:

37 LOSS RATIOS--DISABILITY COVERAGE EXEMPTIONS. Sections 217 and 218
38 of this act apply to all insurers and to every disability insurance

1 policy form filed for approval in this state after the effective date
2 of this section, except:

3 (1) Additional indemnity and premium waiver forms for use only in
4 conjunction with life insurance policies;

5 (2) Medicare supplement policy forms that are regulated by chapter
6 48.66 RCW;

7 (3) Credit insurance policy forms issued pursuant to chapter 48.34
8 RCW;

9 (4) Group policy forms other than:

10 (a) Specified disease policy forms;

11 (b) Policy forms, other than loss of income forms, as to which all
12 or substantially all of the premium is paid by the individuals insured
13 thereunder;

14 (c) Policy forms, other than loss of income forms, for issue to
15 single employers insuring less than one hundred employees;

16 (5) Policy forms filed by health care service contractors or health
17 maintenance organizations;

18 (6) Policy forms initially approved, including subsequent requests
19 for rate increases and modifications of rate manuals.

20 NEW SECTION. Sec. 220. A new section is added to chapter 48.20
21 RCW to read as follows:

22 LOSS RATIOS--DISABILITY COVERAGE DEFINITIONS. (1) The "expected
23 loss ratio" is a prospective calculation and shall be calculated as the
24 projected "benefits incurred" divided by the projected "premiums
25 earned" and shall be based on the actuary's best projections of the
26 future experience within the "calculating period."

27 (2) The "actual loss ratio" is a retrospective calculation and
28 shall be calculated as the "benefits incurred" divided by the "premiums
29 earned," both measured from the beginning of the "calculating period"
30 to the date of the loss ratio calculations.

31 (3) The "overall loss ratio" shall be calculated as the "benefits
32 incurred" divided by the "premiums earned" over the entire "calculating
33 period" and may involve both retrospective and prospective data.

34 (4) The "calculating period" is the time span over which the
35 actuary expects the premium rates, whether level or increasing, to
36 remain adequate in accordance with his or her best estimate of future
37 experience and during which the actuary does not expect to request a
38 rate increase.

1 (5) The "benefits incurred" is the "claims incurred" plus any
2 increase, or less any decrease, in the "reserves."

3 (6) The "claims incurred" means:

4 (a) Claims paid during the accounting period; plus

5 (b) The change in the liability for claims that have been reported
6 but not paid; plus

7 (c) The change in the liability for claims that have not been
8 reported but which may reasonably be expected.

9 The "claims incurred" does not include expenses incurred in
10 processing the claims, home office or field overhead, acquisition and
11 selling costs, taxes or other expenses, contributions to surplus, or
12 profit.

13 (7) The "reserves," as referred to in sections 217 and 218 of this
14 act include:

15 (a) Active life disability reserves;

16 (b) Additional reserves whether for a specific liability purpose or
17 not;

18 (c) Contingency reserves;

19 (d) Reserves for select morbidity experience; and

20 (e) Increased reserves that may be required by the commissioner.

21 (8) The "premiums earned" means the premiums, less experience
22 credits, refunds, or dividends, applicable to an accounting period
23 whether received before, during, or after such period.

24 (9) Renewal provisions are defined as follows:

25 (a) "Guaranteed renewable" means renewal cannot be declined by the
26 insurance company for any reason, but the insurance company can revise
27 rates on a class basis.

28 (b) "Noncancellable" means renewal cannot be declined nor can rates
29 be revised by the insurance company.

30 **PART III--BENEFITS AND SERVICE DELIVERY**

31 NEW SECTION. **Sec. 301.** A new section is added to chapter 48.43
32 RCW to read as follows:

33 **EMERGENCY MEDICAL SERVICES.** (1) When conducting a review of the
34 necessity and appropriateness of emergency services or making a benefit
35 determination for emergency services:

36 (a) A health carrier shall cover emergency services necessary to
37 screen and stabilize a covered person if a prudent layperson acting

1 reasonably would have believed that an emergency medical condition
2 existed. In addition, a health carrier shall not require prior
3 authorization of such services provided prior to the point of
4 stabilization if a prudent layperson acting reasonably would have
5 believed that an emergency medical condition existed. With respect to
6 care obtained from a nonparticipating hospital emergency department, a
7 health carrier shall cover emergency services necessary to screen and
8 stabilize a covered person if a prudent layperson would have reasonably
9 believed that use of a participating hospital emergency department
10 would result in a delay that would worsen the emergency, or if a
11 provision of federal, state, or local law requires the use of a
12 specific provider or facility. In addition, a health carrier shall not
13 require prior authorization of such services provided prior to the
14 point of stabilization if a prudent layperson acting reasonably would
15 have believed that an emergency medical condition existed and that use
16 of a participating hospital emergency department would result in a
17 delay that would worsen the emergency.

18 (b) If an authorized representative of a health carrier authorizes
19 coverage of emergency services, the health carrier shall not
20 subsequently retract its authorization after the emergency services
21 have been provided, or reduce payment for an item or service furnished
22 in reliance on approval, unless the approval was based on a material
23 misrepresentation about the covered person's health condition made by
24 the provider of emergency services.

25 (c) Coverage of emergency services may be subject to applicable
26 copayments, coinsurance, and deductibles, and a health carrier may
27 impose reasonable differential cost-sharing arrangements for emergency
28 services rendered by nonparticipating providers, if such differential
29 between cost-sharing amounts applied to emergency services rendered by
30 participating provider versus nonparticipating provider does not exceed
31 fifty dollars. Differential cost sharing for emergency services may
32 not be applied when a covered person presents to a nonparticipating
33 hospital emergency department rather than a participating hospital
34 emergency department when the health carrier requires preauthorization
35 for postevaluation or poststabilization emergency services if:

36 (i) Due to circumstances beyond the covered person's control, the
37 covered person was unable to go to a participating hospital emergency
38 department in a timely fashion without serious impairment to the
39 covered person's health; or

1 (ii) A prudent layperson possessing an average knowledge of health
2 and medicine would have reasonably believed that he or she would be
3 unable to go to a participating hospital emergency department in a
4 timely fashion without serious impairment to the covered person's
5 health.

6 (d) If a health carrier requires preauthorization for
7 postevaluation or poststabilization services, the health carrier shall
8 provide access to an authorized representative twenty-four hours a day,
9 seven days a week, to facilitate review. In order for postevaluation
10 or poststabilization services to be covered by the health carrier, the
11 provider or facility must make a documented good faith effort to
12 contact the covered person's health carrier within thirty minutes of
13 stabilization, if the covered person needs to be stabilized. The
14 health carrier's authorized representative is required to respond to a
15 telephone request for preauthorization from a provider or facility
16 within thirty minutes. Failure of the health carrier to respond within
17 thirty minutes constitutes authorization for the provision of
18 immediately required medically necessary postevaluation and
19 poststabilization services, unless the health carrier documents that it
20 made a good faith effort but was unable to reach the provider or
21 facility within thirty minutes after receiving the request.

22 (e) A health carrier shall immediately arrange for an alternative
23 plan of treatment for the covered person if a nonparticipating
24 emergency provider and health plan cannot reach an agreement on which
25 services are necessary beyond those immediately necessary to stabilize
26 the covered person consistent with state and federal laws.

27 (2) Nothing in this section is to be construed as prohibiting the
28 health carrier from requiring notification within the time frame
29 specified in the contract for inpatient admission or as soon thereafter
30 as medically possible but no less than twenty-four hours. Nothing in
31 this section is to be construed as preventing the health carrier from
32 reserving the right to require transfer of a hospitalized covered
33 person upon stabilization. Follow-up care that is a direct result of
34 the emergency must be obtained in accordance with the health plan's
35 usual terms and conditions of coverage. All other terms and conditions
36 of coverage may be applied to emergency services.

37 **PART IV--MISCELLANEOUS**

1 NEW SECTION. **Sec. 401.** COMMON TITLE. This act shall be known as
2 the consumer assistance and insurance market stabilization act.

3 NEW SECTION. **Sec. 402.** Part headings and section captions used in
4 this act are not part of the law.

5 NEW SECTION. **Sec. 403.** SEVERABILITY CLAUSE. If any provision of
6 this act or its application to any person or circumstance is held
7 invalid, the remainder of the act or the application of the provision
8 to other persons or circumstances is not affected.

9 NEW SECTION. **Sec. 404.** EFFECTIVE DATES. (1) Sections 105 through
10 109 and 301 of this act take effect January 1, 1998.

11 (2) Section 112 of this act is necessary for the immediate
12 preservation of the public peace, health, or safety, or support of the
13 state government and its existing public institutions, and takes effect
14 July 1, 1997."

15 Correct the title accordingly.

16 EFFECT: Makes numerous corrections to statutory references.
17 Strikes redundant language. Corrects use of terms, e.g., "provider,"
18 "physician," "covered person," "enrollee," "subscriber," "clinical
19 peer," and "health care professional." Deletes definition of "lawful
20 third-party payer." Clarifies content of carriers' annual report to
21 the Insurance Commissioner. Requires a carrier to appoint a health
22 care professional with appropriate qualifications to assess the
23 clinical aspects of expedited reviews. Restores to the statute a
24 grievance procedure for providers. Delinks the Basic Health Plan from
25 the model Basic Health Plan that must be offered by all carriers.

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