2018-S AMH MURR H2879.1

SHB 2018 - H AMD TO H AMD (H-2836.2/97) **300 FAILED 3-18-97**
By Representative Murray

On page 38, after line 5 of the amendment, insert the following:

"**Sec. 212.** RCW 48.41.100 and 1995 c 34 s 5 are each amended to read as follows:

(1) Any individual person who is a resident of this state is eligible for coverage upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on health insurance, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one member within six months of the date of application. Evidence of rejection may be waived in accordance with rules adopted by the board.

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

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

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

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

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

Renumber the remaining sections consecutively and correct internal references accordingly.

Beginning on page 38, line 29 of the amendment, after "(a)" strike all material through "(r)" on page 39, line 36, and insert "Prevention services, consistent with the schedule established by the United States public health service;

(b) Well child care;

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

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

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

((~~(d)~~)) (f) Drugs ((~~and contraceptive devices~~)) requiring a prescription;

((~~(e)~~)) (g) Reproductive health services;

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

((~~(f)~~)) (i) Services of a home health agency;

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

((~~(h)~~)) (k) Oxygen;

((~~(i)~~)) (l) Anesthesia services;

((~~(j)~~)) (m) Prostheses, other than dental;

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

((~~(l)~~)) (o) Diagnostic x-rays and laboratory tests;

((~~(m)~~)) (p) Oral surgery limited to the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or

repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

((~~(n)~~)) (q) Maternity care services, including obstetric, prenatal, and postbirth care, as provided in the managed care plan to be designed by the pool board of directors;

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

((~~(o)~~)) (s) Hospice services;

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

((~~(q)~~)) (u)"

On page 40, after line 25 of the amendment, insert the following:

"**Sec. 213.** RCW 48.41.120 and 1989 c 121 s 8 are each amended to read as follows:

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

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

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

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

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

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

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

(5) Out of pocket cost for managed care enrollees must not exceed one hundred dollars per day for inpatient care, ten dollars per visit for outpatient care, and twenty percent of the cost of nongeneric prescription drugs."

Renumber the remaining sections consecutively and correct internal references accordingly.

EFFECT: Deletes from statute the Pool lifetime benefit cap of $500,000. Modifies the Health Insurance Pool benefit package by striking the maximum inpatient days allowed, adding prevention and well child care services to the Pool plan, and clarifying reproductive health services and maternity care services. Separates the deduction requirements of Pool indemnity and managed care plans. Limits managed care out-of-pocket cost to $100 per day for inpatient care, $10 for office visits, and 20% of nongeneric Drug cost.

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