

ENGROSSED SUBSTITUTE HOUSE BILL 2018

**State of Washington**                    **55th Legislature**                    **1997 Regular Session**

**By** House Committee on Health Care (originally sponsored by Representatives Dyer, Grant, Backlund, Quall, Zellinsky, Sheldon, Sherstad, Morris, Parlette, Scott and Skinner)

Read first time 03/05/97.

1            AN ACT Relating to health insurance reform; amending RCW 48.43.055,  
2 48.43.005, 48.43.025, 48.43.035, 48.20.028, 48.44.022, 48.46.064,  
3 48.41.030, 48.41.060, 48.41.080, 48.41.110, 48.41.200, and 48.41.130;  
4 reenacting and amending RCW 70.47.060; adding new sections to chapter  
5 41.05 RCW; adding new sections to chapter 48.43 RCW; adding a new  
6 section to chapter 74.09 RCW; adding a new section to chapter 48.44  
7 RCW; adding a new section to chapter 48.46 RCW; adding a new section to  
8 chapter 48.21 RCW; adding new sections to chapter 48.20 RCW; creating  
9 new sections; repealing RCW 48.46.100; providing effective dates; and  
10 declaring an emergency.

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

**HEALTH INSURANCE REFORM**

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2 PART I--CONSUMER PROTECTIONS

3 NEW SECTION. **Sec. 101.** UTILIZATION REVIEW--INTENT. The  
4 legislature intends that the delivery of quality health care services  
5 to individuals in the state of Washington be consistent with a wise use  
6 of resources. It is therefore the purpose of this act to define  
7 standards for utilization review of health care services and to promote  
8 the delivery of health care in a cost-effective manner. The  
9 legislature reaffirms its commitment to improving health care services  
10 through encouraging the availability of effective and consistent  
11 utilization review throughout this state. The legislature believes  
12 that standards for utilization review will help assure quality  
13 oversight of individual case evaluations in this state.

14 NEW SECTION. **Sec. 102.** A new section is added to chapter 41.05  
15 RCW to read as follows:

16 UTILIZATION REVIEW--DEFINITIONS. Unless the context clearly  
17 requires otherwise, the definitions in this section apply throughout  
18 sections 103 and 104 of this act:

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

25 (2) "Review organization" means an entity performing utilization  
26 review, including a disability insurer regulated under chapter 48.20 or  
27 48.21 RCW, health care service contractor as defined in RCW 48.44.010,  
28 or health maintenance organization as defined in RCW 48.46.020, and  
29 entities affiliated with, under contract with, or acting on behalf of  
30 a health carrier.

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

1        NEW SECTION.    **Sec. 103.**    A new section is added to chapter 41.05  
2 RCW to read as follows:

3        UTILIZATION REVIEW--REVIEW ORGANIZATION.    (1) Beginning on January  
4 1, 1998, every review organization that performs utilization review of  
5 inpatient medical and surgical benefits and outpatient medical and  
6 surgical benefits for residents of this state shall meet the standards  
7 set forth in this section and section 104 of this act.

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

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

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

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

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

26       (f) Review organizations shall maintain a documented utilization  
27 review program description and written utilization review criteria  
28 based on reasonable medical evidence.    The program must include a  
29 method for reviewing and updating criteria.    Review organizations shall  
30 make utilization review criteria available upon request to the  
31 participating provider involved in a specific case under review.

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

34       (2) The Washington state health care authority shall periodically  
35 examine review organization accreditation standards of the utilization  
36 review accreditation commission, the national committee for quality  
37 assurance, and other national accreditation organizations for  
38 appropriateness and, if deemed appropriate, shall adopt rules exempting  
39 a review organization from the requirements of section 104 of this act

1 if certified by a national credentialing entity approved by the  
2 authority. The powers of the Washington state health care authority  
3 set forth in this section are transferred to the office of the  
4 insurance commissioner on January 1, 2001.

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

7 UTILIZATION REVIEW--STANDARDS. (1) Notification of an initial  
8 determination by the review organization to certify an admission,  
9 length of stay, extension of stay, or service or procedure must be  
10 mailed or otherwise communicated to the provider of record or the  
11 enrollee, or the enrollee's authorized representative, or both, within  
12 two business days of the determination and following the receipt of all  
13 information necessary to complete the review.

14 (2) Notification of an initial determination by the review  
15 organization to deny an admission, length of stay, extension of stay,  
16 or service or procedure must be mailed or otherwise communicated to the  
17 provider of record or the enrollee, or the enrollee's authorized  
18 representative, or both, within one business day of the determination  
19 and following the receipt of all information necessary to complete the  
20 review.

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

24 (a) The review organization's decision in clear terms and the  
25 rationale in sufficient detail for the enrollee to respond further to  
26 the review organization's decision; and

27 (b) The procedures to initiate an appeal of an adverse  
28 determination.

29 (4) Health care facilities and providers shall cooperate with the  
30 reasonable efforts of review organizations to ensure that all necessary  
31 enrollee information is available in a timely fashion by phone during  
32 normal business hours. Health care facilities and providers shall  
33 allow on-site review of medical records by review organizations. These  
34 provisions are subject to the requirements regarding health care  
35 information disclosure in chapter 70.02 RCW.

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

1 UTILIZATION REVIEW--LIMITED RECORD ACCESS. In performing a  
2 utilization review, a review organization is limited to access to  
3 specific health carrier information necessary to complete the review  
4 being performed.

5 NEW SECTION. **Sec. 106.** GRIEVANCE PROCEDURES--INTENT. The  
6 legislature is committed to the efficient use of state resources in  
7 promoting public health and protecting the rights of individuals in the  
8 state of Washington. The purpose of this act is to provide standards  
9 for the establishment and maintenance of procedures by health carriers  
10 to assure that covered persons have the opportunity for the appropriate  
11 resolution of their grievances, as defined in this act.

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

14 GRIEVANCE PROCEDURES--STANDARDS. (1) Every health carrier shall  
15 use written procedures for receiving and resolving grievances from  
16 covered persons. At each level of review of a grievance, the health  
17 carrier shall include a person or persons with sufficient background  
18 and authority to deliberate the merits of the grievance and establish  
19 appropriate terms of resolution. The health carrier's medical director  
20 or designee shall be available to participate in the review of any  
21 grievance involving a clinical issue or issues. A grievance that  
22 includes an issue of clinical quality of care as determined by the  
23 health carrier's medical director or designee may be directed to the  
24 health carrier's quality assurance committee for review and comment.  
25 Nothing in this section alters any protections afforded under statutes  
26 relating to confidentiality and nondiscoverability of quality assurance  
27 activities and information.

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

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

1 (3)(a) A grievance may be submitted by a covered person or a  
2 representative acting on behalf of the covered person through written  
3 authority to assure protection of the covered person's private  
4 information. Within three working days of receiving a grievance, the  
5 health carrier shall acknowledge in writing the receipt of the  
6 grievance and the department name and address where additional  
7 information may be submitted by the covered person or authorized  
8 representative of the covered person. The health carrier shall process  
9 the grievance in a reasonable length of time not to exceed thirty days  
10 from receipt of the written grievance. If the grievance involves the  
11 collection of information from sources external to the health carrier  
12 and its participating providers, the health carrier has an additional  
13 thirty days to process the covered person's grievance.

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

18 (i) The health carrier's decision in clear terms and the rationale  
19 in sufficient detail for the covered person or authorized  
20 representative of the covered person to respond further to the health  
21 carrier's decision; and

22 (ii) When the health carrier's decision is not wholly favorable to  
23 the covered person, a description of the process to obtain a second  
24 level grievance review of the decision, including the time frames  
25 required for submission of a request by the covered person or  
26 authorized representative of the covered person.

27 (4)(a) A health carrier shall provide a second level grievance  
28 review for those covered persons who are dissatisfied with the first  
29 level grievance review decision and who submit a written request for  
30 review. The second level review process shall include an opportunity  
31 for the covered person or authorized representative of the covered  
32 person to appear in person before the representative or representatives  
33 of the health carrier. The covered person or authorized representative  
34 of the covered person must ask for a personal appearance in the written  
35 request for a second level review.

36 (b) The health carrier shall process the grievance in a reasonable  
37 length of time, not to exceed thirty days from receipt of the request  
38 for a second level review. The time required to resolve the second  
39 level review may be extended for a specified period if mutually agreed

1 upon by the covered person or authorized representative of the covered  
2 person and the health carrier.

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

5 (i) The second level review panel shall be comprised of  
6 representatives of the health carrier not otherwise participating in  
7 the first level review. If the grievance involves a clinical issue or  
8 issues, the health carrier shall appoint a health care professional  
9 with appropriate qualifications who was not previously involved with  
10 the grievance under review and shall ensure reasonable access to board-  
11 certified specialty providers as typically manage the issue under  
12 review;

13 (ii) The review panel shall schedule the review meeting to  
14 reasonably accommodate the covered person or authorized representative  
15 of the covered person and not unreasonably deny a request for  
16 postponement of the review requested by the covered person or  
17 authorized representative of the covered person; and

18 (iii) The health carrier shall notify the covered person or  
19 authorized representative of the covered person in writing at least  
20 fifteen days in advance of the scheduled review date unless a shorter  
21 time frame is agreed to by the health carrier and the covered person.  
22 The review meeting shall be held at a location within the health  
23 carrier's service area that is reasonably accessible to the covered  
24 person or authorized representative of the covered person. In cases  
25 where a face-to-face meeting is not practical for geographic reasons,  
26 a health carrier shall offer the covered person or authorized  
27 representative of the covered person the opportunity to communicate  
28 with the review panel, at the health carrier's expense, by conference  
29 call, video conferencing, or other appropriate technology as determined  
30 by the health carrier.

31 (d) The health carrier shall issue a written decision to the  
32 covered person or authorized representative of the covered person  
33 within five working days of completing the review meeting. The  
34 decision shall include:

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

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



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

3 (e) Determination of a grievance at the final level review that is  
4 unfavorable to the covered person may be submitted by the covered  
5 person or authorized representative of the covered person to nonbinding  
6 mediation. Mediation shall be conducted under mediation rules similar  
7 to those of the American arbitration association, the center for public  
8 resources, the judicial arbitration and mediation service, RCW  
9 7.70.100, or any other rules of mediation agreed to by the parties.

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

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

15 (a) A description of the grievance, the date received by the health  
16 carrier, and the name and identification number of the covered person;  
17 and

18 (b) A statement as to which level of the grievance procedure the  
19 grievance has been brought, the date at which it was brought to each  
20 level, the decision reached at each level, and a summary description of  
21 the rationale for the decision.

22 (7) Each health carrier shall make an annual report available to  
23 the commissioner. The report shall include for each type of health  
24 benefit plan offered by the health carrier: The number of covered  
25 lives; the total number of grievances received divided into the  
26 following categories: Access, health carrier customer service, health  
27 care provider or facility service, claim payment, and dispute  
28 resolution; the number of grievances resolved at each level; and the  
29 total number of favorable and unfavorable decisions.

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

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

37 (10) A health carrier shall establish written procedures for the  
38 expedited review of a grievance involving a situation where the time to  
39 resolve a grievance according to the procedures set forth in this

1 section would seriously jeopardize the life or health of a covered  
2 person. A request for an expedited review may be submitted orally or  
3 in writing by a covered person or authorized representative of the  
4 covered person. A health carrier's procedures for establishing an  
5 expedited review process shall include the following:

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

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

14 (c) All necessary information, including the health carrier's  
15 decision, shall be transmitted between the health carrier and the  
16 covered person or authorized representative of the covered person by  
17 telephone, facsimile, or the most expeditious method available as  
18 determined by the health carrier.

19 (d) A health carrier shall make a decision and notify the covered  
20 person or authorized representative of the covered person as  
21 expeditiously as the medical condition of the covered person requires,  
22 but no more than two business days after the request for expedited  
23 review is received by the health carrier. If the expedited review is  
24 a concurrent review determination, the service shall be continued  
25 without liability to the covered person until the covered person or  
26 authorized representative of the covered person has been notified of  
27 the decision by the health carrier.

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

34 (f) In any case where the expedited review process does not resolve  
35 a difference of opinion between a health carrier and the covered  
36 person, the covered person or authorized representative of the covered  
37 person may request a second level grievance review. In conducting the  
38 second level grievance review, the health carrier shall adhere to time  
39 frames that are reasonable under the circumstances, but in no event to

1 exceed the time frames specified in subsection (4) of this section  
2 pertaining to second level grievance review.

3 (11) The Washington state health care authority shall periodically  
4 examine grievance procedure accreditation standards of the national  
5 committee for quality assurance or other national accreditation  
6 organizations for appropriateness and, if deemed appropriate, shall  
7 adopt rules exempting a health carrier from the requirements of this  
8 section if certified by a national accreditation organization approved  
9 by the authority. The powers of the Washington state health care  
10 authority set forth in this section are transferred to the office of  
11 the insurance commissioner on January 1, 2001.

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

14 GRIEVANCE PROCEDURE FOR HEALTH CARE PROVIDERS. Each health carrier  
15 as defined under RCW 48.43.005 shall file with the commissioner its  
16 procedures for review and adjudication of complaints initiated by  
17 ~~((covered persons or))~~ a health care provider~~((s))~~. Procedures filed  
18 under this section shall provide a fair review for consideration of  
19 complaints. Every health carrier shall provide reasonable means  
20 whereby ~~((any person))~~ a health care provider aggrieved by actions of  
21 the health carrier may be heard in person or by their authorized  
22 representative on their written request for review. If the health  
23 carrier fails to grant or reject such request within thirty days after  
24 it is made, the complaining ~~((person))~~ provider may proceed as if the  
25 complaint had been rejected. A complaint that has been rejected by the  
26 health carrier may be submitted to nonbinding mediation. Mediation  
27 shall be conducted pursuant to mediation rules similar to those of the  
28 American arbitration association, the center for public resources, the  
29 judicial arbitration and mediation service, RCW 7.70.100, or any other  
30 rules of mediation agreed to by the parties.

31 NEW SECTION. **Sec. 109.** GRIEVANCE PROCEDURES--REPEALER. RCW  
32 48.46.100 and 1975 1st ex.s. c 290 s 11 are each repealed.

33 NEW SECTION. **Sec. 110.** NETWORK ADEQUACY--INTENT. The legislature  
34 declares that it is in the public interest that health carriers  
35 utilizing provider networks use reasonable means of assessing that  
36 their provider networks are adequate to provide covered services to

1 their enrollees. The legislature finds that empirical assessment of  
2 provider network adequacy is in developmental stages, and that rigid,  
3 formulaic approaches are unworkable and inhibit innovation and  
4 approaches tailored to meet the needs of varying communities and  
5 populations. The legislature therefore finds that, given these  
6 limitations, an assessment is needed to determine whether network  
7 adequacy requirements are needed and, if necessary, whether the type of  
8 measures used by current accreditation programs, such as the national  
9 committee on quality assurance, meets these needs.

10 NEW SECTION. **Sec. 111.** NETWORK ADEQUACY--STUDY AND RESTRICTION.

11 (1) The department of health, in consultation with the office of the  
12 insurance commissioner, the department of social and health services,  
13 the health care authority, the health care policy board, consumers,  
14 providers, and health carriers, shall review the need for network  
15 adequacy requirements. The review must include an evaluation of the  
16 approaches used by the national committee on quality assurance and any  
17 similar, nationally recognized accreditation programs. The department  
18 shall submit its report and recommendations to the health care  
19 committees of the legislature by January 1, 1998, and include  
20 recommendations on:

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

23 (b) If standards are needed, to what extent such standards can be  
24 made consistent with the national committee on quality assurance  
25 standards, and whether national committee on quality assurance  
26 accredited carriers, or carriers accredited by other, nationally  
27 recognized accreditation programs, should be exempted from state review  
28 and requirements;

29 (c) Whether and how the state could promote uniformity of approach  
30 across commercial purchaser requirements and state and federal agency  
31 requirements so as to assure adequate consumer access while promoting  
32 the most efficient use of public and private health care financial  
33 resources;

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

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

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

5 (2) No agency may engage in rule making relating to network  
6 adequacy until the legislature has reviewed the findings and  
7 recommendations of the study and has passed legislation authorizing the  
8 department of health or other appropriate agency to engage in rule  
9 making in this area in accordance with the policy direction set by the  
10 legislature.

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

13 ACCESS PLAN REQUIREMENTS. (1) Beginning July 1, 1997, health  
14 carriers, as defined in RCW 48.43.005, shall develop and update  
15 annually an access plan that meets the requirements of this section for  
16 each of the health care networks that the carrier offers in this state.  
17 The health carrier shall make the access plans available on its  
18 business premises and shall provide nonproprietary information to any  
19 interested party upon request. The carrier shall prepare an access  
20 plan prior to offering a health plan utilizing a substantially  
21 different health care network. The plan shall include, at least, the  
22 following:

23 (a) The health carrier's network of providers and facilities by  
24 license, certification and registration type, and by geographic  
25 location;

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

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

31 (2) On or before August 1, 1997, each health carrier shall submit  
32 its access plan or plans to the Washington state health care authority  
33 for purposes of assisting the authority with its report and  
34 recommendations on network adequacy standards required under section  
35 111 of this act.

36 (3) The Washington state health care authority shall periodically  
37 examine accreditation standards of the national committee for quality  
38 assurance or other national accreditation organizations for

1 appropriateness and, if deemed appropriate, shall adopt rules exempting  
2 a health carrier from the requirements of this section if certified by  
3 a national accreditation organization approved by the authority. The  
4 powers of the Washington state health care authority set forth in this  
5 section are transferred to the office of the insurance commissioner on  
6 January 1, 2001.

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

9 MEDICAL ASSISTANCE WAIVERS. To the extent that federal statutes or  
10 regulations, or provisions of waivers granted to the department of  
11 social and health services by the federal department of health and  
12 human services, include standards that differ from the minimums stated  
13 in sections 101 through 107, 110, and 112 of this act, those sections  
14 do not apply to contracts with health carriers awarded pursuant to RCW  
15 74.09.522.

16 **PART II--MARKETPLACE STABILITY**

17 NEW SECTION. **Sec. 201.** LEGISLATIVE INTENT. The legislature  
18 intends that individuals in the state of Washington have access to  
19 affordable individual health plan coverage. The legislature reaffirms  
20 its commitment to guaranteed issue and renewability, portability, and  
21 limitations on use of preexisting condition exclusions. The  
22 legislature also finds that the lack of incentives for individuals to  
23 purchase and maintain coverage independent of anticipated need for  
24 health care has contributed to soaring health care claims experience in  
25 many individual health plans. The legislature therefore intends that  
26 refinements be made to the state's individual market reform laws to  
27 provide needed incentives and to help assure that more affordable  
28 coverage is accessible to Washington residents.

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

31 DEFINITIONS. Unless otherwise specifically provided, the  
32 definitions in this section apply throughout this chapter.

33 (1) "Adjusted community rate" means the rating method used to  
34 establish the premium for health plans adjusted to reflect actuarially

1 demonstrated differences in utilization or cost attributable to  
2 geographic region, age, family size, and use of wellness activities.

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

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

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

9 (5) "Covered person" or "enrollee" means a person covered by a  
10 health plan including an enrollee, subscriber, policyholder,  
11 beneficiary of a group plan, or individual covered by any other health  
12 plan.

13 ~~((3))~~ (6) "Dependent" means, at a minimum, the enrollee's legal  
14 spouse and unmarried dependent children who qualify for coverage under  
15 the enrollee's health benefit plan.

16 (7) "Eligible employee" means an employee who works on a full-time  
17 basis with a normal work week of thirty or more hours. The term  
18 includes a self-employed individual, including a sole proprietor, a  
19 partner of a partnership, and may include an independent contractor, if  
20 the self-employed individual, sole proprietor, partner, or independent  
21 contractor is included as an employee under a health benefit plan of a  
22 small employer, but does not work less than thirty hours per week and  
23 derives at least seventy-five percent of his or her income from a trade  
24 or business through which he or she has attempted to earn taxable  
25 income and for which he or she has filed the appropriate internal  
26 revenue service form. Persons covered under a health benefit plan  
27 pursuant to the consolidated omnibus budget reconciliation act of 1986  
28 shall not be considered eligible employees for purposes of minimum  
29 participation requirements of chapter 265, Laws of 1995.

30 ~~((4))~~ (8) "Emergency medical condition" means the emergent and  
31 acute onset of a symptom or symptoms, including severe pain, that would  
32 lead a prudent layperson acting reasonably to believe that a health  
33 condition exists that requires immediate medical attention, if failure  
34 to provide medical attention would result in serious impairment to  
35 bodily functions or serious dysfunction of a bodily organ or part, or  
36 would place the person's health in serious jeopardy.

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

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

5       (~~(5)~~) (11) "Grievance" means a written complaint submitted by or  
6 on behalf of a covered person regarding: (a) Denial of payment for  
7 medical services or nonprovision of medical services included in the  
8 covered person's health benefit plan, or (b) service delivery issues  
9 other than denial of payment for medical services or nonprovision of  
10 medical services, including dissatisfaction with medical care, waiting  
11 time for medical services, provider or staff attitude or demeanor, or  
12 dissatisfaction with service provided by the health carrier.

13       (12) "Health care facility" or "facility" means hospices licensed  
14 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,  
15 rural health care facilities as defined in RCW 70.175.020, psychiatric  
16 hospitals licensed under chapter 71.12 RCW, nursing homes licensed  
17 under chapter 18.51 RCW, community mental health centers licensed under  
18 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed  
19 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical  
20 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment  
21 facilities licensed under chapter 70.96A RCW, and home health agencies  
22 licensed under chapter 70.127 RCW, and includes such facilities if  
23 owned and operated by a political subdivision or instrumentality of the  
24 state and such other facilities as required by federal law and  
25 implementing regulations.

26       (~~(6)~~) (13) "Health care provider" or "provider" means:

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

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

32       (~~(7)~~) (14) "Health care service" means that service offered or  
33 provided by health care facilities and health care providers relating  
34 to the prevention, cure, or treatment of illness, injury, or disease.

35       (~~(8)~~) (15) "Health carrier" or "carrier" means a disability  
36 insurer regulated under chapter 48.20 or 48.21 RCW, a health care  
37 service contractor as defined in RCW 48.44.010, or a health maintenance  
38 organization as defined in RCW 48.46.020.



1       (~~(9)~~) (16) "Health plan" or "health benefit plan" means any  
2 policy, contract, or agreement offered by a health carrier to provide,  
3 arrange, reimburse, or pay for health care services except the  
4 following:

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

6       (b) Medicare supplemental health insurance governed by chapter  
7 48.66 RCW;

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

10       (d) Disability income;

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

14       (f) Workers' compensation coverage;

15       (g) Accident only coverage;

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

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

19       (j) Dental only and vision only coverage.

20       (~~(10)~~) (17) "Basic health plan services" means that schedule of  
21 covered health services, including the description of how those  
22 benefits are to be administered, that are required to be delivered to  
23 an enrollee under the basic health plan, as revised from time to time.

24       (~~(11)~~) (18) "Preexisting condition" means any medical condition,  
25 illness, or injury that existed any time prior to the effective date of  
26 coverage.

27       (~~(12)~~) (19) "Premium" means all sums charged, received, or  
28 deposited by a health carrier as consideration for a health plan or the  
29 continuance of a health plan. Any assessment or any "membership,"  
30 "policy," "contract," "service," or similar fee or charge made by a  
31 health carrier in consideration for a health plan is deemed part of the  
32 premium. "Premium" shall not include amounts paid as enrollee point-  
33 of-service cost-sharing.

34       (~~(13)~~) (20) "Small employer" means any person, firm, corporation,  
35 partnership, association, political subdivision except school  
36 districts, or self-employed individual that is actively engaged in  
37 business that, on at least fifty percent of its working days during the  
38 preceding calendar quarter, employed no more than fifty eligible  
39 employees, with a normal work week of thirty or more hours, the

1 majority of whom were employed within this state, and is not formed  
2 primarily for purposes of buying health insurance and in which a bona  
3 fide employer-employee relationship exists. In determining the number  
4 of eligible employees, companies that are affiliated companies, or that  
5 are eligible to file a combined tax return for purposes of taxation by  
6 this state, shall be considered an employer. Subsequent to the  
7 issuance of a health plan to a small employer and for the purpose of  
8 determining eligibility, the size of a small employer shall be  
9 determined annually. Except as otherwise specifically provided, a  
10 small employer shall continue to be considered a small employer until  
11 the plan anniversary following the date the small employer no longer  
12 meets the requirements of this definition. The term "small employer"  
13 includes a self-employed individual or sole proprietor. The term  
14 "small employer" also includes a self-employed individual or sole  
15 proprietor who derives at least seventy-five percent of his or her  
16 income from a trade or business through which the individual or sole  
17 proprietor has attempted to earn taxable income and for which he or she  
18 has filed the appropriate internal revenue service form 1040, schedule  
19 C or F, for the previous taxable year.

20 ~~((14))~~ (21) "Wellness activity" means an explicit program of an  
21 activity consistent with department of health guidelines, such as,  
22 smoking cessation, injury and accident prevention, reduction of alcohol  
23 misuse, appropriate weight reduction, exercise, automobile and  
24 motorcycle safety, blood cholesterol reduction, and nutrition education  
25 for the purpose of improving enrollee health status and reducing health  
26 service costs.

27 ~~((15) "Basic health plan" means the plan described under chapter  
28 70.47 RCW, as revised from time to time.))~~

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

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

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

35 (b) No carrier may deny, exclude, or otherwise limit coverage for  
36 an individual's preexisting health conditions; except that a carrier  
37 may impose a three-month benefit waiting period for preexisting  
38 conditions for which medical advice was given, or for which a health

1 care provider recommended or provided treatment within three months  
2 before the effective date of coverage.

3 (c) All health carriers offering any individual health plan to any  
4 individual must allow open enrollment to eligible applicants into all  
5 individual health plans offered by the carrier during the full month of  
6 July of each year. The individual health plans exempt from guaranteed  
7 continuity under RCW 48.43.035(4) are exempt from this requirement.  
8 All applications for open enrollment coverage must be complete and  
9 postmarked to or received by the carrier in the month of July in any  
10 year following the effective date of this section. Coverage for these  
11 applicants must begin the first day of the next month subject to  
12 receipt of timely payment consistent with the terms of the policies.

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

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

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

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

22 (e) If a carrier refuses to enroll an applicant, it must offer to  
23 enroll the applicant in the Washington state health insurance pool in  
24 an expeditious manner as determined by the board of directors of the  
25 pool. Declination by the applicant to enroll must be done in written  
26 form.

27 (f) Carriers may not refuse enrollment based upon health evaluation  
28 criteria to otherwise eligible applicants who have been covered either  
29 continuously or for any part of the three-month period immediately  
30 preceding the date of application for the new individual health plan  
31 under a comparable group or individual health benefit plan with  
32 substantially similar benefits. For purposes of this subsection, in  
33 addition to provisions in RCW 48.43.015, the following publicly  
34 administered coverage shall be considered comparable health benefit  
35 plans: The basic health plan established by chapter 70.47 RCW; the  
36 medical assistance program established by chapter 74.09 RCW; and the  
37 Washington state health insurance pool, established by chapter 48.41  
38 RCW, as long as the person is continuously enrolled in the pool until  
39 the next open enrollment period. If the person is enrolled in the pool

1 for less than three months, she or he will be credited for that period  
2 up to three months.

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

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

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

17 (2) No carrier may avoid the requirements of this section through  
18 the creation of a new rate classification or the modification of an  
19 existing rate classification. A new or changed rate classification  
20 will be deemed an attempt to avoid the provisions of this section if  
21 the new or changed classification would substantially discourage  
22 applications for coverage from individuals or groups who are higher  
23 than average health risks. ((These)) The provisions of this section  
24 apply only to individuals who are Washington residents.

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

27 GUARANTEED ISSUE AND CONTINUITY OF COVERAGE MODIFIED. (1) Except  
28 as otherwise specified in RCW 48.43.025, all health carriers shall  
29 accept for enrollment any state resident within the carrier's service  
30 area and provide or assure the provision of all covered services  
31 regardless of age, sex, family structure, ethnicity, race, health  
32 condition, geographic location, employment status, socioeconomic  
33 status, other condition or situation, or the provisions of RCW  
34 49.60.174(2). The insurance commissioner may grant a temporary  
35 exemption from this subsection, if, upon application by a health  
36 carrier the commissioner finds that the clinical, financial, or  
37 administrative capacity to serve existing enrollees will be impaired if

1 a health carrier is required to continue enrollment of additional  
2 eligible individuals.

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

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

15 (a) Nonpayment of premium;

16 (b) Violation of published policies of the carrier approved by the  
17 insurance commissioner;

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

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

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

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

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

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

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

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

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

1       (e)) A carrier is withdrawing from a service area or from a  
2 segment of its service area because the carrier has demonstrated to the  
3 insurance commissioner that the carrier's clinical, financial, or  
4 administrative capacity to serve enrollees would be exceeded.

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

7       (a) The health carrier provides notice to each covered person  
8 provided coverage of this type of such discontinuation or modification  
9 at least ninety days prior to the date of the discontinuation or  
10 modification of coverage;

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

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

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

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

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

30       (a)(i) Individual; or

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

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

33       (b) Only if:

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

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

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

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

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

13 The administrator has the following powers and duties:

14 (1) To design and from time to time revise a schedule of covered  
15 basic health care services, including physician services, inpatient and  
16 outpatient hospital services, prescription drugs and medications, and  
17 other services that may be necessary for basic health care. In  
18 addition, the administrator may offer as basic health plan services  
19 chemical dependency services, mental health services and organ  
20 transplant services; however, no one service or any combination of  
21 these three services shall increase the actuarial value of the basic  
22 health plan benefits by more than five percent excluding inflation, as  
23 determined by the office of financial management. All subsidized and  
24 nonsubsidized enrollees in any participating managed health care system  
25 under the Washington basic health plan shall be entitled to receive  
26 (~~covered basic health care services~~) covered basic health care  
27 services in return for premium payments to the plan. The schedule of  
28 services shall emphasize proven preventive and primary health care and  
29 shall include all services necessary for prenatal, postnatal, and well-  
30 child care. However, with respect to coverage for groups of subsidized  
31 enrollees who are eligible to receive prenatal and postnatal services  
32 through the medical assistance program under chapter 74.09 RCW, the  
33 administrator shall not contract for such services except to the extent  
34 that such services are necessary over not more than a one-month period  
35 in order to maintain continuity of care after diagnosis of pregnancy by  
36 the managed care provider. The schedule of services shall also include  
37 a separate schedule of basic health care services for children,  
38 eighteen years of age and younger, for those subsidized or

1 nonsubsidized enrollees who choose to secure basic coverage through the  
2 plan only for their dependent children. In designing and revising the  
3 schedule of services, the administrator shall consider the guidelines  
4 for assessing health services under the mandated benefits act of 1984,  
5 RCW 48.42.080, and such other factors as the administrator deems  
6 appropriate.

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

14 (2)(a) To design and implement a structure of periodic premiums due  
15 the administrator from subsidized enrollees that is based upon gross  
16 family income, giving appropriate consideration to family size and the  
17 ages of all family members. The enrollment of children shall not  
18 require the enrollment of their parent or parents who are eligible for  
19 the plan. The structure of periodic premiums shall be applied to  
20 subsidized enrollees entering the plan as individuals pursuant to  
21 subsection (9) of this section and to the share of the cost of the plan  
22 due from subsidized enrollees entering the plan as employees pursuant  
23 to subsection (10) of this section.

24 (b) To determine the periodic premiums due the administrator from  
25 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees  
26 shall be in an amount equal to the cost charged by the managed health  
27 care system provider to the state for the plan plus the administrative  
28 cost of providing the plan to those enrollees and the premium tax under  
29 RCW 48.14.0201.

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

36 (d) To develop, as an offering by all health carriers providing  
37 coverage identical to the basic health plan, as configured on January  
38 1, 1996, a basic health plan model plan (~~(benefits package)~~) with  
39 uniformity in enrollee cost-sharing requirements.



1 (3) To design and implement a structure of enrollee cost sharing  
2 due a managed health care system from subsidized and nonsubsidized  
3 enrollees. The structure shall discourage inappropriate enrollee  
4 utilization of health care services, and may utilize copayments,  
5 deductibles, and other cost-sharing mechanisms, but shall not be so  
6 costly to enrollees as to constitute a barrier to appropriate  
7 utilization of necessary health care services.

8 (4) To limit enrollment of persons who qualify for subsidies so as  
9 to prevent an overexpenditure of appropriations for such purposes.  
10 Whenever the administrator finds that there is danger of such an  
11 overexpenditure, the administrator shall close enrollment until the  
12 administrator finds the danger no longer exists.

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

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

21 (7) To solicit and accept applications from managed health care  
22 systems, as defined in this chapter, for inclusion as eligible basic  
23 health care providers under the plan. The administrator shall endeavor  
24 to assure that covered basic health care services are available to any  
25 enrollee of the plan from among a selection of two or more  
26 participating managed health care systems. In adopting any rules or  
27 procedures applicable to managed health care systems and in its  
28 dealings with such systems, the administrator shall consider and make  
29 suitable allowance for the need for health care services and the  
30 differences in local availability of health care resources, along with  
31 other resources, within and among the several areas of the state.  
32 Contracts with participating managed health care systems shall ensure  
33 that basic health plan enrollees who become eligible for medical  
34 assistance may, at their option, continue to receive services from  
35 their existing providers within the managed health care system if such  
36 providers have entered into provider agreements with the department of  
37 social and health services.

38 (8) To receive periodic premiums from or on behalf of subsidized  
39 and nonsubsidized enrollees, deposit them in the basic health plan

1 operating account, keep records of enrollee status, and authorize  
2 periodic payments to managed health care systems on the basis of the  
3 number of enrollees participating in the respective managed health care  
4 systems.

5 (9) To accept applications from individuals residing in areas  
6 served by the plan, on behalf of themselves and their spouses and  
7 dependent children, for enrollment in the Washington basic health plan  
8 as subsidized or nonsubsidized enrollees, to establish appropriate  
9 minimum-enrollment periods for enrollees as may be necessary, and to  
10 determine, upon application and on a reasonable schedule defined by the  
11 authority, or at the request of any enrollee, eligibility due to  
12 current gross family income for sliding scale premiums. No subsidy  
13 may be paid with respect to any enrollee whose current gross family  
14 income exceeds twice the federal poverty level or, subject to RCW  
15 70.47.110, who is a recipient of medical assistance or medical care  
16 services under chapter 74.09 RCW. If, as a result of an eligibility  
17 review, the administrator determines that a subsidized enrollee's  
18 income exceeds twice the federal poverty level and that the enrollee  
19 knowingly failed to inform the plan of such increase in income, the  
20 administrator may bill the enrollee for the subsidy paid on the  
21 enrollee's behalf during the period of time that the enrollee's income  
22 exceeded twice the federal poverty level. If a number of enrollees  
23 drop their enrollment for no apparent good cause, the administrator may  
24 establish appropriate rules or requirements that are applicable to such  
25 individuals before they will be allowed to reenroll in the plan.

26 (10) To accept applications from business owners on behalf of  
27 themselves and their employees, spouses, and dependent children, as  
28 subsidized or nonsubsidized enrollees, who reside in an area served by  
29 the plan. The administrator may require all or the substantial  
30 majority of the eligible employees of such businesses to enroll in the  
31 plan and establish those procedures necessary to facilitate the orderly  
32 enrollment of groups in the plan and into a managed health care system.  
33 The administrator may require that a business owner pay at least an  
34 amount equal to what the employee pays after the state pays its portion  
35 of the subsidized premium cost of the plan on behalf of each employee  
36 enrolled in the plan. Enrollment is limited to those not eligible for  
37 medicare who wish to enroll in the plan and choose to obtain the basic  
38 health care coverage and services from a managed care system  
39 participating in the plan. The administrator shall adjust the amount

1 determined to be due on behalf of or from all such enrollees whenever  
2 the amount negotiated by the administrator with the participating  
3 managed health care system or systems is modified or the administrative  
4 cost of providing the plan to such enrollees changes.

5 (11) To determine the rate to be paid to each participating managed  
6 health care system in return for the provision of covered basic health  
7 care services to enrollees in the system. Although the schedule of  
8 covered basic health care services will be the same for similar  
9 enrollees, the rates negotiated with participating managed health care  
10 systems may vary among the systems. In negotiating rates with  
11 participating systems, the administrator shall consider the  
12 characteristics of the populations served by the respective systems,  
13 economic circumstances of the local area, the need to conserve the  
14 resources of the basic health plan trust account, and other factors the  
15 administrator finds relevant.

16 (12) To monitor the provision of covered services to enrollees by  
17 participating managed health care systems in order to assure enrollee  
18 access to good quality basic health care, to require periodic data  
19 reports concerning the utilization of health care services rendered to  
20 enrollees in order to provide adequate information for evaluation, and  
21 to inspect the books and records of participating managed health care  
22 systems to assure compliance with the purposes of this chapter. In  
23 requiring reports from participating managed health care systems,  
24 including data on services rendered enrollees, the administrator shall  
25 endeavor to minimize costs, both to the managed health care systems and  
26 to the plan. The administrator shall coordinate any such reporting  
27 requirements with other state agencies, such as the insurance  
28 commissioner and the department of health, to minimize duplication of  
29 effort.

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

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

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

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

3       TENURE DISCOUNTS--INDIVIDUAL DISABILITY COVERAGE.     (1)(a) An  
4 insurer offering any health benefit plan to any individual shall offer  
5 and actively market to all individuals a health benefit plan providing  
6 benefits identical to the schedule of covered health (~~services~~)  
7 benefits that are required to be delivered to an individual enrolled in  
8 the basic health plan subject to RCW 48.43.035. Nothing in this  
9 subsection shall preclude an insurer from offering, or an individual  
10 from purchasing, other health benefit plans that may have more or less  
11 comprehensive benefits than the basic health plan, provided such plans  
12 are in accordance with this chapter. An insurer offering a health  
13 benefit plan that does not include benefits provided in the basic  
14 health plan shall clearly disclose these differences to the individual  
15 in a brochure approved by the commissioner.

16       (b) A health benefit plan shall provide coverage for hospital  
17 expenses and services rendered by a physician licensed under chapter  
18 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
19 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411,  
20 48.20.412, 48.20.416, and 48.20.420 if the health benefit plan is the  
21 mandatory offering under (a) of this subsection that provides benefits  
22 identical to the basic health plan, to the extent these requirements  
23 differ from the basic health plan.

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

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

- 30       (i) Geographic area;
- 31       (ii) Family size;
- 32       (iii) Age; (~~and~~)
- 33       (iv) Tenure discounts; and
- 34       (v) Wellness activities.

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

1 (c) The insurer shall be permitted to develop separate rates for  
2 individuals age sixty-five or older for coverage for which medicare is  
3 the primary payer and coverage for which medicare is not the primary  
4 payer. Both rates shall be subject to the requirements of this  
5 subsection.

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

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

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

16 (i) Changes to the family composition;

17 (ii) Changes to the health benefit plan requested by the  
18 individual; or

19 (iii) Changes in government requirements affecting the health  
20 benefit plan.

21 (g) For the purposes of this section, a health benefit plan that  
22 contains a restricted network provision shall not be considered similar  
23 coverage to a health benefit plan that does not contain such a  
24 provision, provided that the restrictions of benefits to network  
25 providers result in substantial differences in claims costs. This  
26 subsection does not restrict or enhance the portability of benefits as  
27 provided in RCW 48.43.015.

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

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

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

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

1 TENURE DISCOUNTS--HEALTH CARE SERVICE CONTRACTORS. (1)(a) A health  
2 care service contractor offering any health benefit plan to any  
3 individual shall offer and actively market to all individuals a health  
4 benefit plan providing benefits identical to the schedule of covered  
5 health (~~services~~) benefits that are required to be delivered to an  
6 individual enrolled in the basic health plan, subject to the provisions  
7 in RCW 48.43.035. Nothing in this subsection shall preclude a  
8 contractor from offering, or an individual from purchasing, other  
9 health benefit plans that may have more or less comprehensive benefits  
10 than the basic health plan, provided such plans are in accordance with  
11 this chapter. A contractor offering a health benefit plan that does  
12 not include benefits provided in the basic health plan shall clearly  
13 disclose these differences to the individual in a brochure approved by  
14 the commissioner.

15 (b) A health benefit plan shall provide coverage for hospital  
16 expenses and services rendered by a physician licensed under chapter  
17 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
18 48.44.225, 48.44.240, 48.44.245, 48.44.290, 48.44.300, 48.44.310,  
19 48.44.320, 48.44.325, 48.44.330, 48.44.335, 48.44.340, 48.44.344,  
20 48.44.360, 48.44.400, 48.44.440, 48.44.450, and 48.44.460 if the health  
21 benefit plan is the mandatory offering under (a) of this subsection  
22 that provides benefits identical to the basic health plan, to the  
23 extent these requirements differ from the basic health plan.

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

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

- 29 (i) Geographic area;
- 30 (ii) Family size;
- 31 (iii) Age; (~~and~~)
- 32 (iv) Tenure discounts; and
- 33 (v) Wellness activities.

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

38 (c) The health care service contractor shall be permitted to  
39 develop separate rates for individuals age sixty-five or older for

1 coverage for which medicare is the primary payer and coverage for which  
2 medicare is not the primary payer. Both rates shall be subject to the  
3 requirements of this subsection.

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

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

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

14 (i) Changes to the family composition;

15 (ii) Changes to the health benefit plan requested by the  
16 individual; or

17 (iii) Changes in government requirements affecting the health  
18 benefit plan.

19 (g) For the purposes of this section, a health benefit plan that  
20 contains a restricted network provision shall not be considered similar  
21 coverage to a health benefit plan that does not contain such a  
22 provision, provided that the restrictions of benefits to network  
23 providers result in substantial differences in claims costs. This  
24 subsection does not restrict or enhance the portability of benefits as  
25 provided in RCW 48.43.015.

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

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

32 (4) As used in this section and RCW 48.44.023 "health benefit  
33 plan," "small employer," "basic health plan," "adjusted community  
34 rates," and "wellness activities" mean the same as defined in RCW  
35 48.43.005.

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

1 TENURE DISCOUNTS--HEALTH MAINTENANCE ORGANIZATIONS. (1)(a) A  
2 health maintenance organization offering any health benefit plan to any  
3 individual shall offer and actively market to all individuals a health  
4 benefit plan providing benefits identical to the schedule of covered  
5 health (~~services~~) benefits that are required to be delivered to an  
6 individual enrolled in the basic health plan, subject to the provisions  
7 in RCW 48.43.035. Nothing in this subsection shall preclude a health  
8 maintenance organization from offering, or an individual from  
9 purchasing, other health benefit plans that may have more or less  
10 comprehensive benefits than the basic health plan, provided such plans  
11 are in accordance with this chapter. A health maintenance organization  
12 offering a health benefit plan that does not include benefits provided  
13 in the basic health plan shall clearly disclose these differences to  
14 the individual in a brochure approved by the commissioner.

15 (b) A health benefit plan shall provide coverage for hospital  
16 expenses and services rendered by a physician licensed under chapter  
17 18.57 or 18.71 RCW but is not subject to the requirements of RCW  
18 48.46.275, (~~(48.26.280 [48.46.280])~~) 48.46.280, 48.46.285, 48.46.290,  
19 48.46.350, 48.46.355, 48.46.375, 48.46.440, 48.46.480, 48.46.510,  
20 48.46.520, and 48.46.530 if the health benefit plan is the mandatory  
21 offering under (a) of this subsection that provides benefits identical  
22 to the basic health plan, to the extent these requirements differ from  
23 the basic health plan.

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

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

- 29 (i) Geographic area;
- 30 (ii) Family size;
- 31 (iii) Age; (~~and~~)
- 32 (iv) Tenure discounts; and
- 33 (v) Wellness activities.

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

38 (c) The health maintenance organization shall be permitted to  
39 develop separate rates for individuals age sixty-five or older for



1 coverage for which medicare is the primary payer and coverage for which  
2 medicare is not the primary payer. Both rates shall be subject to the  
3 requirements of this subsection.

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

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

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

14 (i) Changes to the family composition;

15 (ii) Changes to the health benefit plan requested by the  
16 individual; or

17 (iii) Changes in government requirements affecting the health  
18 benefit plan.

19 (g) For the purposes of this section, a health benefit plan that  
20 contains a restricted network provision shall not be considered similar  
21 coverage to a health benefit plan that does not contain such a  
22 provision, provided that the restrictions of benefits to network  
23 providers result in substantial differences in claims costs. This  
24 subsection does not restrict or enhance the portability of benefits as  
25 provided in RCW 48.43.015.

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

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

32 (4) As used in this section and RCW 48.46.066, "health benefit  
33 plan," "basic health plan," "adjusted community rate," "small  
34 employer," and "wellness activities" mean the same as defined in RCW  
35 48.43.005.

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

1 HEALTH INSURANCE POOL--DEFINITIONS. As used in this chapter, the  
2 following terms have the meaning indicated, unless the context requires  
3 otherwise:

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

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

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

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

14 (5) "Health care facility" has the same meaning as in RCW  
15 70.38.025.

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

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

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

35 (9) "Health plan" means any arrangement by which persons, including  
36 dependents or spouses, covered or making application to be covered  
37 under this pool, have access to hospital and medical benefits or  
38 reimbursement including any group or individual disability insurance  
39 policy; health care service contract; health maintenance agreement;

1 uninsured arrangements of group or group-type contracts including  
2 employer self-insured, cost-plus, or other benefit methodologies not  
3 involving insurance or not governed by Title 48 RCW; coverage under  
4 group-type contracts which are not available to the general public and  
5 can be obtained only because of connection with a particular  
6 organization or group; and coverage by medicare or other governmental  
7 benefits. This term includes coverage through "health ((insurance))  
8 coverage" as defined under this section, and specifically excludes  
9 those types of programs excluded under the definition of "health  
10 ((insurance)) coverage" in subsection (8) of this section.

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

13 ~~((11))~~ "Medical assistance" means coverage under Title XIX of the  
14 federal Social Security Act (42 U.S.C., Sec. 1396 et seq.) and chapter  
15 74.09 RCW.

16 ~~((12))~~ (11) "Medicare" means coverage under Title XVIII of the  
17 Social Security Act, (42 U.S.C. Sec. 1395 et seq., as amended).

18 ~~((13))~~ (12) "Member" means any commercial insurer which provides  
19 disability insurance, any health care service contractor, and any  
20 health maintenance organization licensed under Title 48 RCW. "Member"  
21 shall also mean, as soon as authorized by federal law, employers and  
22 other entities, including a self-funding entity and employee welfare  
23 benefit plans that provide health plan benefits in this state on or  
24 after May 18, 1987. "Member" does not include any insurer, health care  
25 service contractor, or health maintenance organization whose products  
26 are exclusively dental products or those products excluded from the  
27 definition of "health ((insurance)) coverage" set forth in subsection  
28 (8) of this section.

29 (13) "Network provider" means a health care provider who has  
30 contracted in writing with the pool administrator to accept payment  
31 from and to look solely to the pool according to the terms of the pool  
32 health plans.

33 (14) "Plan of operation" means the pool, including articles, by-  
34 laws, and operating rules, adopted by the board pursuant to RCW  
35 48.41.050.

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

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

3       (~~(16)~~) (17) "Substantially equivalent health plan" means a  
4 "health plan" as defined in subsection (9) of this section which, in  
5 the judgment of the board or the administrator, offers persons  
6 including dependents or spouses covered or making application to be  
7 covered by this pool an overall level of benefits deemed approximately  
8 equivalent to the minimum benefits available under this pool.

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

11       HEALTH INSURANCE POOL--BOARD POWERS MODIFIED. The board shall have  
12 the general powers and authority granted under the laws of this state  
13 to insurance companies, health care service contractors, and health  
14 maintenance organizations, licensed or registered to (~~transact~~) offer  
15 or provide the kinds of (~~insurance~~) health coverage defined under  
16 this title. In addition thereto, the board may:

17       (1) Enter into contracts as are necessary or proper to carry out  
18 the provisions and purposes of this chapter including the authority,  
19 with the approval of the commissioner, to enter into contracts with  
20 similar pools of other states for the joint performance of common  
21 administrative functions, or with persons or other organizations for  
22 the performance of administrative functions;

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

26       (3) Establish appropriate rates, rate schedules, rate adjustments,  
27 expense allowances, agent referral fees, claim reserve formulas and any  
28 other actuarial functions appropriate to the operation of the pool.  
29 Rates shall not be unreasonable in relation to the coverage provided,  
30 the risk experience, and expenses of providing the coverage. Rates and  
31 rate schedules may be adjusted for appropriate risk factors such as age  
32 and area variation in claim costs and shall take into consideration  
33 appropriate risk factors in accordance with established actuarial  
34 underwriting practices consistent with Washington state individual plan  
35 rating requirements under RCW 48.20.028, 48.44.022, and 48.46.064;

36       (4) Assess members of the pool in accordance with the provisions of  
37 this chapter, and make advance interim assessments as may be reasonable  
38 and necessary for the organizational or interim operating expenses.

1 Any interim assessments will be credited as offsets against any regular  
2 assessments due following the close of the year;

3 (5) Issue policies of (~~insurance~~) health coverage in accordance  
4 with the requirements of this chapter;

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

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

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

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

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

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

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

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

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

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

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

1 (a) All eligibility and administrative claim payment functions  
2 relating to the pool;

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

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

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

12 (ii) Taking steps necessary to offer and administer managed care  
13 benefit plans; and

14 (iii) Evaluating the eligibility of each claim for payment by the  
15 pool;

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

19 (e) Following the close of each accounting year, determination of  
20 net paid and earned premiums, the expense of administration, and the  
21 paid and incurred losses for the year and reporting this information to  
22 the board and the commissioner on a form as prescribed by the  
23 commissioner.

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

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

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

37 (2) The administrator shall prepare a brochure outlining the  
38 benefits and exclusions of the pool policy in plain language. After

1 approval by the board of directors, such brochure shall be made  
2 reasonably available to participants or potential participants. The  
3 health insurance policy issued by the pool shall pay only usual,  
4 customary, and reasonable charges for medically necessary eligible  
5 health care services rendered or furnished for the diagnosis or  
6 treatment of illnesses, injuries, and conditions which are not  
7 otherwise limited or excluded. Eligible expenses are the usual,  
8 customary, and reasonable charges for the health care services and  
9 items for which benefits are extended under the pool policy. Such  
10 benefits shall at minimum include, but not be limited to, the following  
11 services or related items:

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

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

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

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

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

34 (f) Services of a home health agency;

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

37 (h) Oxygen;

38 (i) Anesthesia services;

39 (j) Prostheses, other than dental;

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

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

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

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

13 (o) Services of a physical therapist and services of a speech  
14 therapist;

15 ~~((+o))~~ (p) Hospice services;

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

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

21 ~~((+2))~~ (3) The board shall design and employ cost containment  
22 measures and requirements such as, but not limited to, care  
23 coordination, provider network limitations, preadmission certification,  
24 and concurrent inpatient review which may make the pool more cost-  
25 effective.

26 ~~((+3))~~ (4) The pool benefit policy may contain benefit  
27 limitations, exceptions, and ~~((reductions))~~ cost shares such as  
28 copayments, coinsurance, and deductibles that are consistent with  
29 managed care products, except that differential cost shares may be  
30 adopted by the board for nonnetwork providers under point of service  
31 plans. The pool benefit policy cost shares and limitations must be  
32 consistent with those that are generally included in health  
33 ~~((insurance))~~ plans ~~((and are))~~ approved by the insurance commissioner;  
34 however, no limitation, exception, or reduction may be ~~((approved))~~  
35 used that would exclude coverage for any disease, illness, or injury.

36 (5) The pool may not reject an individual for health plan coverage  
37 based upon preexisting conditions of the individual or deny, exclude,  
38 or otherwise limit coverage for an individual's preexisting health  
39 conditions; except that it may impose a three-month benefit waiting



1 period for preexisting conditions for which medical advice was given,  
2 or for which a health care provider recommended or provided treatment,  
3 within three months before the effective date of coverage. The pool  
4 may not avoid the requirements of this section through the creation of  
5 a new rate classification or the modification of an existing rate  
6 classification.

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

9 HEALTH INSURANCE POOL--RATE MODIFIED. The pool shall determine the  
10 standard risk rate by calculating the average group standard rate for  
11 groups comprised of up to ~~((ten))~~ fifty persons charged by the five  
12 largest members offering coverages in the state comparable to the pool  
13 coverage. In the event five members do not offer comparable coverage,  
14 the standard risk rate shall be established using reasonable actuarial  
15 techniques and shall reflect anticipated experience and expenses for  
16 such coverage. Maximum rates for pool coverage shall be one hundred  
17 fifty percent for the indemnity health plan and one hundred twenty-five  
18 percent for managed care plans of the rates established as applicable  
19 for group standard risks in groups comprised of up to ~~((ten))~~ fifty  
20 persons(~~(. All rates and rate schedules shall be submitted to the~~  
21 ~~commissioner for approval)~~).

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

24 HEALTH INSURANCE POOL--SUBSTANTIAL EQUIVALENT CLARIFIED. All  
25 policy forms issued by the pool shall conform in substance to prototype  
26 forms developed by the pool, and shall in all other respects conform to  
27 the requirements of this chapter, and shall be filed with and approved  
28 by the commissioner before they are issued. The pool shall not issue  
29 a pool policy to any individual who, on the effective date of the  
30 coverage applied for, already has or would have coverage substantially  
31 equivalent to a pool policy as an insured or covered dependent, or who  
32 would be eligible for such coverage if he or she elected to obtain it  
33 at a lesser premium rate. However, coverage provided by the basic  
34 health plan, as established pursuant to chapter 70.47 RCW, shall not be  
35 deemed substantially equivalent for the purposes of this section.

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

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

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

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

9        (c) Eighty percent for group contract forms other than small group  
10 contract forms; and

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

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

15        (3) A health care service contractor may charge the rate for  
16 prepayment of health care services in any contract identified in RCW  
17 48.44.020(1) upon filing of the rate with the commissioner. If the  
18 commissioner disapproves the rate, the commissioner shall explain in  
19 writing the specific reasons for the disapproval. A health care  
20 service contractor may continue to charge such rate pending a final  
21 order in any hearing held under chapters 48.04 and 34.05 RCW, or if  
22 applicable, pending a final order in any appeal. Any amount charged  
23 that is determined in a final order on appeal to be unreasonable in  
24 relation to the benefits provided is subject to refund.

25        (4) For the purposes of this section:

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

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

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

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

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

- 1 (b) Seventy percent for franchise plan contract forms;  
2 (c) Eighty percent for group contract forms other than small group  
3 contract forms; and  
4 (d) Seventy-five percent for small group contract forms.

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

8 (3) A health maintenance organization may charge the rate for  
9 prepayment of health care services in any contract identified in RCW  
10 48.46.060(1) upon filing of the rate with the commissioner. If the  
11 commissioner disapproves the rate, the commissioner shall explain in  
12 writing the specific reasons for the disapproval. A health maintenance  
13 organization may continue to charge such rate pending a final order in  
14 any hearing held under chapters 48.04 and 34.05 RCW, or if applicable,  
15 pending a final order in any appeal. Any amount charged that is  
16 determined in a final order on appeal to be unreasonable in relation to  
17 the benefits provided is subject to refund.

18 (4) For the purposes of this section:

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

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

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

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

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

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

1	Number of Certificate Holders	Minimum Overall
2	at Issue, Renewal, or Rerating	Loss Ratio
3	9 or less	60%
4	10 to 24	65%
5	25 to 49	70%
6	50 to 99	75%
7	100 or more	80%

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

12 (4) The calculating period may vary with the benefit and premium  
13 provisions. The company may be required to demonstrate the  
14 reasonableness of the calculating period chosen by the actuary  
15 responsible for the premium calculations.

16 (5) A request for a rate increase submitted at the end of the  
17 calculating period shall include a comparison of the actual to the  
18 expected loss ratios and shall employ any accumulation of reserves in  
19 the determination of rates for the selected calculating period and  
20 account for the maintenance of such reserves for future needs. The  
21 request for the rate increase shall be further documented by the  
22 expected loss ratio for the new calculating period.

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

31 (7) The commissioner may approve a series of two or three smaller  
32 rate increases in lieu of one larger increase. These should be  
33 calculated to reduce the lapses and antiselection that often result  
34 from large rate increases. A demonstration of such calculations,  
35 whether for a single rate increase or a series of smaller rate  
36 increases, satisfactory to the commissioner, shall be attached to the  
37 filing.

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

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

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

8 LOSS RATIOS--INDIVIDUAL DISABILITY COVERAGE. The following  
9 standards and requirements apply to individual disability insurance  
10 forms:

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

15 (2) The calculating period may vary with the benefit and renewal  
16 provisions. The company may be required to demonstrate the  
17 reasonableness of the calculating period chosen by the actuary  
18 responsible for the premium calculations. A brief explanation of the  
19 selected calculating period shall accompany the filing.

20 (3) Policy forms, the benefits of which are particularly exposed to  
21 the effects of inflation and whose premium income may be particularly  
22 vulnerable to an eroding persistency and other similar forces, shall  
23 use a relatively short calculating period reflecting the uncertainties  
24 of estimating the risks involved. Policy forms based on more  
25 dependable statistics may employ a longer calculating period. The  
26 calculating period may be the lifetime of the contract for guaranteed  
27 renewable and noncancellable policy forms if such forms provide  
28 benefits that are supported by reliable statistics and that are  
29 protected from inflationary or eroding forces by such factors as fixed  
30 dollar coverages, inside benefit limits, or the inherent nature of the  
31 benefits. The calculating period may be as short as one year for  
32 coverages that are based on statistics of minimal reliability or that  
33 are highly exposed to inflation.

34 (4) A request for a rate increase to be effective at the end of the  
35 calculating period shall include a comparison of the actual to the  
36 expected loss ratios, shall employ any accumulation of reserves in the  
37 determination of rates for the new calculating period, and shall  
38 account for the maintenance of such reserves for future needs. The

1 request for the rate increase shall be further documented by the  
2 expected loss ratio for the new calculating period.

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

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

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

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

22 LOSS RATIOS--DISABILITY COVERAGE EXEMPTIONS. Sections 217 and 218  
23 of this act apply to all insurers and to every disability insurance  
24 policy form filed for approval in this state after the effective date  
25 of this section, except:

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

28 (2) Medicare supplement policy forms that are regulated by chapter  
29 48.66 RCW;

30 (3) Credit insurance policy forms issued pursuant to chapter 48.34  
31 RCW;

32 (4) Group policy forms other than:

33 (a) Specified disease policy forms;

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

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

1 (5) Policy forms filed by health care service contractors or health  
2 maintenance organizations;

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

5 NEW SECTION. **Sec. 220.** A new section is added to chapter 48.20  
6 RCW to read as follows:

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

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

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

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

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

26 (6) The "claims incurred" means:

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

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

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

32 The "claims incurred" does not include expenses incurred in  
33 processing the claims, home office or field overhead, acquisition and  
34 selling costs, taxes or other expenses, contributions to surplus, or  
35 profit.

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

38 (a) Active life disability reserves;

1 (b) Additional reserves whether for a specific liability purpose or  
2 not;

3 (c) Contingency reserves;

4 (d) Reserves for select morbidity experience; and

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

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

9 (9) Renewal provisions are defined as follows:

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

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

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

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

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

21 (a) A health carrier shall cover emergency services necessary to  
22 screen and stabilize a covered person if a prudent layperson acting  
23 reasonably would have believed that an emergency medical condition  
24 existed. In addition, a health carrier shall not require prior  
25 authorization of such services provided prior to the point of  
26 stabilization if a prudent layperson acting reasonably would have  
27 believed that an emergency medical condition existed. With respect to  
28 care obtained from a nonparticipating hospital emergency department, a  
29 health carrier shall cover emergency services necessary to screen and  
30 stabilize a covered person if a prudent layperson would have reasonably  
31 believed that use of a participating hospital emergency department  
32 would result in a delay that would worsen the emergency, or if a  
33 provision of federal, state, or local law requires the use of a  
34 specific provider or facility. In addition, a health carrier shall not  
35 require prior authorization of such services provided prior to the  
36 point of stabilization if a prudent layperson acting reasonably would  
37 have believed that an emergency medical condition existed and that use



1 of a participating hospital emergency department would result in a  
2 delay that would worsen the emergency.

3 (b) If an authorized representative of a health carrier authorizes  
4 coverage of emergency services, the health carrier shall not  
5 subsequently retract its authorization after the emergency services  
6 have been provided, or reduce payment for an item or service furnished  
7 in reliance on approval, unless the approval was based on a material  
8 misrepresentation about the covered person's health condition made by  
9 the provider of emergency services.

10 (c) Coverage of emergency services may be subject to applicable  
11 copayments, coinsurance, and deductibles, and a health carrier may  
12 impose reasonable differential cost-sharing arrangements for emergency  
13 services rendered by nonparticipating providers, if such differential  
14 between cost-sharing amounts applied to emergency services rendered by  
15 participating provider versus nonparticipating provider does not exceed  
16 fifty dollars. Differential cost sharing for emergency services may  
17 not be applied when a covered person presents to a nonparticipating  
18 hospital emergency department rather than a participating hospital  
19 emergency department when the health carrier requires preauthorization  
20 for postevaluation or poststabilization emergency services if:

21 (i) Due to circumstances beyond the covered person's control, the  
22 covered person was unable to go to a participating hospital emergency  
23 department in a timely fashion without serious impairment to the  
24 covered person's health; or

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

30 (d) If a health carrier requires preauthorization for  
31 postevaluation or poststabilization services, the health carrier shall  
32 provide access to an authorized representative twenty-four hours a day,  
33 seven days a week, to facilitate review. In order for postevaluation  
34 or poststabilization services to be covered by the health carrier, the  
35 provider or facility must make a documented good faith effort to  
36 contact the covered person's health carrier within thirty minutes of  
37 stabilization, if the covered person needs to be stabilized. The  
38 health carrier's authorized representative is required to respond to a  
39 telephone request for preauthorization from a provider or facility

1 within thirty minutes. Failure of the health carrier to respond within  
2 thirty minutes constitutes authorization for the provision of  
3 immediately required medically necessary postevaluation and  
4 poststabilization services, unless the health carrier documents that it  
5 made a good faith effort but was unable to reach the provider or  
6 facility within thirty minutes after receiving the request.

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

12 (2) Nothing in this section is to be construed as prohibiting the  
13 health carrier from requiring notification within the time frame  
14 specified in the contract for inpatient admission or as soon thereafter  
15 as medically possible but no less than twenty-four hours. Nothing in  
16 this section is to be construed as preventing the health carrier from  
17 reserving the right to require transfer of a hospitalized covered  
18 person upon stabilization. Follow-up care that is a direct result of  
19 the emergency must be obtained in accordance with the health plan's  
20 usual terms and conditions of coverage. All other terms and conditions  
21 of coverage may be applied to emergency services.

22 **PART IV--MISCELLANEOUS**

23 NEW SECTION. **Sec. 401.** WICKLINE CLAUSE STUDY. (1) There is some  
24 question regarding who should be liable when a health carrier or other  
25 third-party payer refuses to pay for or provide health services  
26 recommended by a health care provider and the patient suffers injury as  
27 a result of not receiving the recommended care. This issue typically  
28 arises in managed care systems, which integrate the financing and  
29 delivery of health care services to covered persons through selected  
30 providers. Contracts between health carriers and providers may address  
31 potential liability issues regarding the relationships between the  
32 carriers and the providers. Some contracts shift potential liability  
33 for a health carrier's decision not to pay for recommended health  
34 services to the provider or patient through what are commonly referred  
35 to as "Wickline clauses." These clauses generally state it is a  
36 medical decision between the provider and patient as to whether the  
37 patient receives services that the carrier refuses to cover; this

1 ignores the fact that the decision not to provide coverage influences  
2 the decision of the patient whether to receive the recommended care.  
3 The legislature intends to review the policy questions raised by this  
4 issue, particularly to what extent the carrier should be able to avoid  
5 liability for its decisions by insulating itself through its contracts  
6 with providers.

7 (2) A joint task force on Wickline clauses shall review the  
8 practice of contractually assigning or avoiding potential liability for  
9 decisions by health carriers or other third-party payers not to pay for  
10 health care services recommended by a health care provider. The task  
11 force shall be comprised of two members of the house of representatives  
12 appointed by the speaker of the house, one from each major caucus, two  
13 members of the senate appointed by the president of the senate, one  
14 from each major caucus, and eight persons appointed by the legislative  
15 members of the task force. The eight nonlegislative persons on the  
16 task force shall consist of: Two representatives of health care  
17 providers; two representatives of health care consumers; two  
18 representatives of health carriers; and two representatives of self-  
19 funded health plans. The legislative members shall organize and  
20 administer the task force. Staffing shall be provided by the office of  
21 program research and senate committee services.

22 (3) The task force shall report to the health care committees of  
23 the legislature by December 1, 1997. The report shall discuss the  
24 policy issues regarding Wickline clauses and the more general issue of  
25 potential liability for decisions of health carriers and others not to  
26 cover health care recommended by the provider. The report may contain  
27 recommendations for the legislature to consider.

28 NEW SECTION. **Sec. 402.** COMMON TITLE. This act shall be known as  
29 the consumer assistance and insurance market stabilization act.

30 NEW SECTION. **Sec. 403.** Part headings and section captions used in  
31 this act are not part of the law.

32 NEW SECTION. **Sec. 404.** SEVERABILITY CLAUSE. If any provision of  
33 this act or its application to any person or circumstance is held  
34 invalid, the remainder of the act or the application of the provision  
35 to other persons or circumstances is not affected.

1        NEW SECTION.   **Sec. 405.**   EFFECTIVE DATES.   (1) Sections 105 through  
2   109 and 301 of this act take effect January 1, 1998.

3        (2) Section 112 of this act is necessary for the immediate  
4   preservation of the public peace, health, or safety, or support of the  
5   state government and its existing public institutions, and takes effect  
6   July 1, 1997.

--- END ---