H-2420.2

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.

AN ACT Relating to health insurance reform; amending RCW 48.43.005, 48.43.025, 48.43.035, 48.20.028, 48.44.022, 48.46.064, 48.41.030, 48.41.060, 48.41.080, 48.41.110, 48.41.200, and 48.41.130; adding new sections to chapter 43.70 RCW; adding new sections to chapter 48.43 RCW; adding a new section to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.21 RCW; adding new sections to chapter 48.20 RCW; creating new sections; repealing RCW 48.43.055 and 48.46.100; providing effective dates; and declaring an emergency.

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

HEALTH INSURANCE REFORM

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PART I--CONSUMER PROTECTIONS

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

NEW SECTION. **Sec. 102.** A new section is added to chapter 43.70 RCW to read as follows:

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

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

(2) "Review organization" means an entity performing utilization review, including a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier. "Review organization" does not include an employer-sponsored self-funded health plan.

(3) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to a patient or group of patients. "Utilization review" does not mean elective requests for clarification of coverage, eligibility or benefits verification, or medical claims adjudication.

NEW SECTION. **Sec. 103.** A new section is added to chapter 43.70 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 104.** A new section is added to chapter 43.70 RCW to read as follows:

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

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

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

(a) The review organization's decision in clear terms and the rationale in sufficient detail for the patient to respond further to the review organization's position; and

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

(4) Hospitals and providers shall cooperate with the reasonable efforts of review organizations to ensure that all necessary patient information is available in a timely fashion by phone during normal business hours. Hospitals and physicians shall allow on-site review of medical records by review organizations. These provisions are subject to the requirements regarding health care information disclosure in chapter 70.02 RCW.

NEW SECTION. **Sec. 105.** A new section is added to chapter 43.70 RCW to read as follows:

UTILIZATION REVIEW--LIMITED RECORD ACCESS. (1) In performing a utilization review, a review organization is limited to access to the records of persons covered by the specific health carrier or lawful third party payer for which the review is performed.

(2) For purposes of this section, "lawful third party payer" means a third party payer that is operating lawfully under state or federal law and may include public or private third party payers, including, by way of illustration and not limitation, public or private insuring entities regulated pursuant to this title; health care coverage programs of the government of the state of Washington under chapter 41.05, 70.47, or 74.09 RCW; health care coverage programs of local governmental units pursuant to chapter 48.62 RCW; any industrial insurance programs under Title 51 RCW; private self-insured employer welfare benefit plans exempt from state insurance regulation by federal law; and the federal government as to any of its health care programs such as medicare, CHAMPUS, or other coverage for federal employees and dependents.

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

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

GRIEVANCE PROCEDURES--STANDARDS. (1) Every health carrier shall use written procedures for receiving and resolving grievances from covered persons. At each level of review of a grievance, the health carrier shall include a person or persons with sufficient background and authority to deliberate the merits of the grievance and establish appropriate terms of resolution. The health carrier’s medical director or designee shall be available to participate in the review of any grievance involving a clinical issue or issues. A grievance that includes an issue of clinical quality of care as determined by the health carrier’s medical director or designee may be directed to the

health carrier's quality assurance committee for review, resolution, and documentation.

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

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

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

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

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

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

(4)(a) A health carrier shall provide a second level grievance review for those covered persons who are dissatisfied with the first

level grievance review decision and who submit a written request for review. The second level review process shall include an opportunity for the covered person or authorized representative of the covered person to appear in person before the representative or representatives of the health carrier to present facts or documents not considered at the first level grievance review. The covered person or authorized representative of the covered person must ask for a personal appearance in the initial request for a second level review.

(b) The health carrier shall process the grievance in a reasonable length of time, not to exceed thirty days from receipt of the request for a second level review. If the request includes a request for an in-person review, the health carrier has an additional twenty-one days to schedule and conduct the review meeting. In no event shall the second level review process exceed fifty-one days from the health carrier's initial receipt of the request unless mutually agreed upon by the covered person or authorized representative of the covered person and the health carrier.

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

(i) The second level review panel shall be comprised of representatives of the health carrier not otherwise participating in the first level review. If the grievance involves a clinical issue or issues, the health carrier shall appoint a clinical peer with appropriate qualifications who was not previously involved with the grievance under review;

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

(iii) The health carrier shall notify the covered person or authorized representative of the covered person in writing at least fifteen days in advance of the scheduled review date unless a shorter time frame is agreed to by the health carrier and the covered person. The review meeting shall be held at a location within the health carrier's service area that is reasonably accessible to the covered person or authorized representative of the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or authorized

representative of the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology as determined by the health carrier.

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

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

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

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

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

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

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

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

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

(7) Each health carrier shall make an annual report available to the commissioner upon reasonable request. The report shall include for each type of health benefit plan offered by the health carrier the number of covered lives, the total number of grievances received, the number of grievances resolved at each level, and the total number of favorable and unfavorable decisions.

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

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

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

(a) Expedited reviews shall be evaluated by an appropriate health care professional appointed by the health carrier.

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

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

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

(e) A health carrier shall provide written confirmation of its decision concerning an expedited review within two working days of providing notification of that decision to the enrollee, if the initial notification was not in writing. The written notification shall

contain the provisions required in subsection (3) of this section pertaining to a first level grievance review.

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

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

NEW SECTION. **Sec. 108.** GRIEVANCE PROCEDURES--REPEALERS. The following acts or parts of acts are each repealed:

(1) RCW 48.43.055 and 1995 c 265 s 20; and

(2) RCW 48.46.100 and 1975 1st ex.s. c 290 s 11.

NEW SECTION. **Sec. 109.** NETWORK ADEQUACY--INTENT. The legislature declares that it is in the public interest that health carriers utilizing provider networks use reasonable means of assessing that their provider networks are adequate to provide covered services to their enrollees. The legislature finds that empirical assessment of provider network adequacy is in developmental stages, and that rigid, formulaic approaches are unworkable and inhibit innovation and approaches tailored to meet the needs of varying communities and populations. The legislature therefore finds that, given these limitations, an assessment is needed to determine whether network adequacy requirements are needed and, if necessary, whether the type of measures used by current accreditation programs, such as the national committee on quality assurance, meets these needs.

NEW SECTION. **Sec. 110.** NETWORK ADEQUACY--STUDY AND RESTRICTION. (1) The department of health, in consultation with the office of the insurance commissioner, the department of social and health services, the health care authority, the health care policy board, consumers, providers, and health carriers, shall review the need for network adequacy requirements. The review must include an evaluation of the approaches used by the national committee on quality assurance and any similar, nationally recognized accreditation programs. The department shall submit its report and recommendations to the health care committees of the legislature by January 1, 1998, and include recommendations on:

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

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

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

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

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

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

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

NEW SECTION. **Sec. 111.** A new section is added to chapter 43.70 RCW to read as follows:

ACCESS PLAN REQUIREMENTS. (1) Beginning July 1, 1997, health carriers, as defined in RCW 48.43.005, shall develop and update annually an access plan that meets the requirements of this section for each of the health care networks that the carrier offers in this state. The health carrier shall make the access plans available on its business premises and shall provide nonproprietary information to any interested party upon request. The carrier shall prepare an access plan prior to offering a health plan utilizing a substantially different health care network. Examples of items that may be included are:

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

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

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

(2) On or before August 1, 1997, each health carrier shall submit its access plan or plans to the department of health for purposes of assisting the department with its report and recommendations on network adequacy standards required under section 110 of this act.

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

NEW SECTION. **Sec. 112.** MEDICAL ASSISTANCE WAIVERS. To the extent that federal statutes or regulations, or provisions of waivers granted to the department of social and health services by the federal department of health and human services, include standards that differ from the minimums stated in sections 101 through 107, 109, and 111 of

this act, those sections do not apply to contracts with health carriers awarded pursuant to RCW 74.09.522.

PART II--MARKETPLACE STABILITY

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

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

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

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

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

(3) "Basic health plan model plan" means a health plan providing benefits identical to the schedule of covered benefits that are required to be delivered to an individual enrolled in the basic health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage.

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

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

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

((~~(13)~~)) (20) "Small employer" means any person, firm, corporation, partnership, association, political subdivision except school districts, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term

"small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

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

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

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

PREEXISTING CONDITION LIMITATIONS MODIFIED. (1) Except as otherwise specified in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Nonpayment of premium;

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

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

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

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

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

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

(h) The health carrier is ceasing to offer a plan in accordance with subsections (5) and (8) of this section.

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

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

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

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

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

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

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

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

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

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

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

(a)(i) Individual; or

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

(B) Large group (51+ members);

(b) Only if:

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

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

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

Sec. 205. RCW 48.20.028 and 1995 c 265 s 13 are each amended to read as follows:

TENURE DISCOUNTS--INDIVIDUAL DISABILITY COVERAGE. (1)(a) An insurer offering any health benefit plan to any individual shall offer

and actively market to all individuals a health benefit plan providing benefits identical to the schedule of covered health ((~~services~~)) benefits that are required to be delivered to an individual enrolled in the basic health plan subject to RCW 48.43.035. Nothing in this subsection shall preclude an insurer from offering, or an individual from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. An insurer offering a health benefit plan that does not include benefits provided in the basic health plan shall clearly disclose these differences to the individual in a brochure approved by the commissioner.

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

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

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

(i) Geographic area;

(ii) Family size;

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

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

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

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 206. RCW 48.44.022 and 1995 c 265 s 15 are each amended to read as follows:

TENURE DISCOUNTS--HEALTH CARE SERVICE CONTRACTORS. (1)(a) A health care service contractor offering any health benefit plan to any individual shall offer and actively market to all individuals a health benefit plan providing benefits identical to the schedule of covered health ((~~services~~)) benefits that are required to be delivered to an

individual enrolled in the basic health plan, subject to the provisions in RCW 48.43.035. Nothing in this subsection shall preclude a contractor from offering, or an individual from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A contractor offering a health benefit plan that does not include benefits provided in the basic health plan shall clearly disclose these differences to the individual in a brochure approved by the commissioner.

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

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

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

(i) Geographic area;

(ii) Family size;

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

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups

on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 207. RCW 48.46.064 and 1995 c 265 s 17 are each amended to read as follows:

TENURE DISCOUNTS--HEALTH MAINTENANCE ORGANIZATIONS. (1)(a) A health maintenance organization offering any health benefit plan to any individual shall offer and actively market to all individuals a health benefit plan providing benefits identical to the schedule of covered health ((~~services~~)) benefits that are required to be delivered to an individual enrolled in the basic health plan, subject to the provisions

in RCW 48.43.035. Nothing in this subsection shall preclude a health maintenance organization from offering, or an individual from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. A health maintenance organization offering a health benefit plan that does not include benefits provided in the basic health plan shall clearly disclose these differences to the individual in a brochure approved by the commissioner.

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

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

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

(i) Geographic area;

(ii) Family size;

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

(iv) Tenure discounts; and

(v) Wellness activities.

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

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

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups

on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

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

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

(i) Changes to the family composition;

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

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

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

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

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

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

Sec. 208. RCW 48.41.030 and 1989 c 121 s 1 are each amended to read as follows:

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

(1) "Accounting year" means a twelve-month period determined by the board for purposes of record-keeping and accounting. The first accounting year may be more or less than twelve months and, from time

to time in subsequent years, the board may order an accounting year of other than twelve months as may be required for orderly management and accounting of the pool.

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

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

(4) "Commissioner" means the insurance commissioner.

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

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

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

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

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

benefits. This term includes coverage through "health ((~~insurance~~)) coverage" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health ((~~insurance~~)) coverage" in subsection (8) of this section.

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

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

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

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

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

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

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

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

((~~(16)~~)) (17) "Substantially equivalent health plan" means a "health plan" as defined in subsection (9) of this section which, in the judgment of the board or the administrator, offers persons including dependents or spouses covered or making application to be

covered by this pool an overall level of benefits deemed approximately equivalent to the minimum benefits available under this pool.

Sec. 209. RCW 48.41.060 and 1989 c 121 s 3 are each amended to read as follows:

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

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

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

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

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

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

(6) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool,

policy, and other contract design, and any other function within the authority of the pool; and

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

Sec. 210. RCW 48.41.080 and 1989 c 121 s 5 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 211. RCW 48.41.110 and 1987 c 431 s 11 are each amended to read as follows:

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

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of the pool policy in plain language. After approval by the board of directors, such brochure shall be made reasonably available to participants or potential participants. The health insurance policy issued by the pool shall pay only usual, customary, and reasonable charges for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illnesses, injuries, and conditions which are not

otherwise limited or excluded. Eligible expenses are the usual, customary, and reasonable charges for the health care services and items for which benefits are extended under the pool policy. Such benefits shall at minimum include, but not be limited to, the following services or related items:

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

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

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

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

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

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery limited to the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular

joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

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

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

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

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

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

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

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

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

a new rate classification or the modification of an existing rate classification.

Sec. 212. RCW 48.41.200 and 1987 c 431 s 20 are each amended to read as follows:

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

Sec. 213. RCW 48.41.130 and 1987 c 431 s 13 are each amended to read as follows:

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

NEW SECTION. **Sec. 214.** A new section is added to chapter 48.44 RCW to read as follows:

LOSS RATIOS--HEALTH CARE SERVICE CONTRACTORS. (1) For purposes of RCW 48.44.020(2)(d), benefits in a contract shall be deemed reasonable

in relation to the amount charged provided that the anticipated loss ratio is at least:

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

(b) Seventy percent for franchise plan contract forms;

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

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

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

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

(4) For the purposes of this section:

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

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

NEW SECTION. **Sec. 215.** A new section is added to chapter 48.46 RCW to read as follows:

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

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

(b) Seventy percent for franchise plan contract forms;

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

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

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

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

(4) For the purposes of this section:

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

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

NEW SECTION. **Sec. 216.** A new section is added to chapter 48.21 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

(9) The definitions in section 219 of this act and the provisions in section 218 of this act apply to this section.

NEW SECTION. **Sec. 217.** A new section is added to chapter 48.20 RCW to read as follows:

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

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

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

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

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

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

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

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

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

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

LOSS RATIOS--DISABILITY COVERAGE EXEMPTIONS. Sections 216 and 217 of this act apply to all insurers and to every disability insurance policy form filed for approval in this state after the effective date of this section, except:

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

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

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

(4) Group policy forms other than:

(a) Specified disease policy forms;

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

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

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

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

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

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

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

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

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

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

(6) The "claims incurred" means:

(a) Claims paid during the accounting period; plus

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

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

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

(7) The "reserves," as referred to in sections 216 and 217 of this act include:

(a) Active life disability reserves;

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

(c) Contingency reserves;

(d) Reserves for select morbidity experience; and

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

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

(9) Renewal provisions are defined as follows:

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

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

PART III--BENEFITS AND SERVICE DELIVERY

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 302.** COMMON TITLE. This act shall be known as the consumer assistance and insurance market stabilization act.

NEW SECTION. **Sec. 303.** Part headings and section captions used in this act are not part of the law.

NEW SECTION. **Sec. 304.** SEVERABILITY CLAUSE. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 305.** EFFECTIVE DATES. (1) Sections 105 through 108 and 301 of this act take effect January 1, 1998.

(2) Section 111 of this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the

state government and its existing public institutions, and takes effect July 1, 1997.

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