H-1832.3

# HOUSE BILL 2160

**State of Washington 56th Legislature 1999 Regular Session**

**By** Representatives Parlette, Cody and Campbell

Read first time 02/17/1999. Referred to Committee on Health Care.

AN ACT Relating to access to individual health insurance coverage; amending RCW 48.41.020, 48.41.030, 48.41.040, 48.41.090, 48.41.100, 48.41.110, 48.41.120, 48.43.015, and 48.43.025; reenacting and amending RCW 70.47.060; adding new sections to chapter 48.41 RCW; adding a new section to chapter 48.43 RCW; creating new sections; repealing RCW 48.20.028, 48.41.050, 48.41.060, 48.41.080, 48.44.022, and 48.46.064; and declaring an emergency.

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

NEW SECTION. **Sec. 1.** The legislature finds that the following principles must be adopted in order to establish affordable health care for individuals:

(1) Preserve access to appropriate health insurance coverage for individuals regardless of their age, gender, or current health status;

(2) Retain the financial viability and solvency of both public and private programs dedicated to providing insurance coverage;

(3) Create appropriate incentives for consumers to obtain and keep insurance;

(4) Spread the cost of insuring those who need the most care among the broadest community; and

(5) Increase the diversity of benefit packages available for those purchasing insurance in the individual market.

**Sec. 2.** RCW 48.41.020 and 1987 c 431 s 2 are each amended to read as follows:

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

**Sec. 3.** RCW 48.41.030 and 1997 c 337 s 6 are each amended to read as follows:

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~~)) administrator of the Washington state health care authority.

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

(4) "Commissioner" means the insurance commissioner.

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

(6) "Health care facility" has the same meaning as in RCW ((~~70.38.025~~)) 48.43.005.

(7) "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~~)) has the same meaning as in RCW 48.43.005.

(8) "Health care services" ((~~means services for the purpose of preventing, alleviating, curing, or healing human illness or injury~~)) has the same meaning as in RCW 48.43.005.

(9) "Health 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.

(10) "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 coverage" as defined under this section, and specifically excludes those types of programs excluded under the definition of "health coverage" in subsection (9) of this section~~)) has the same meaning as in RCW 48.43.005.

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

(13) "Member" means any commercial insurer which provides disability insurance, stop loss 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 coverage" set forth in subsection (9) of this section.

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

(15) "Plan of operation" means the pool, including articles, by-laws, and operating rules, adopted by the board ((~~pursuant to RCW 48.41.050~~)) under section 6 of this act.

(16) "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.

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

(18) "Standardized risk assessment" means a scientifically valid tool defined by the board that is uniformly applied by all carriers to determine health risk thresholds for enrollment in the individual market or the pool.

(19) "Substantially equivalent health plan" means a "health plan" as defined in subsection (10) of this section which, in the judgment of the ((~~board or the administrator~~)) commissioner, 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. 4.** RCW 48.41.040 and 1989 c 121 s 2 are each amended to read as follows:

(1) There is ((~~hereby~~)) created ((~~a nonprofit entity to be known as~~)) the Washington state health insurance pool. All members in this state on or after May 18, 1987, shall be members of the pool. When authorized by federal law, all self-insured employers shall also be members of the pool.

(2) ((~~Pursuant to chapter 34.05 RCW the commissioner shall, within ninety days after May 18, 1987, give notice to all members of the time and place for the initial organizational meetings of the pool.~~)) A board of directors shall be established((~~, which shall be comprised of nine members. The commissioner shall select three members of the board who shall represent (a) the general public, (b) health care providers, and (c) health insurance agents. The remaining members of the board shall be selected by election from among the members of the pool. The elected members shall, to the extent possible, include at least one representative of health care service contractors, one representative of health maintenance organizations, and one representative of commercial insurers which provides disability insurance. When self-insured organizations become eligible for participation in the pool, the membership of the board shall be increased to eleven and at least one member of the board shall represent the self-insurers~~)) as follows: The administrator and the insurance commissioner as ex officio nonvoting members; three members representing health carriers; one member representing private health care purchasers; one member representing health care providers; two members representing consumers; and two members at large. All nonex officio members shall have voting privileges. The governor shall appoint all nonex officio members and designate a chair to serve at the governor's pleasure.

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

((~~(4) The board shall submit to the commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing pursuant to chapter 34.05 RCW, approve the plan of operation if it is determined to~~

~~assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit a plan of operation within one hundred eighty days after the appointment of the board or any time thereafter fails to submit acceptable amendments to the plan, the commissioner shall, within ninety days after notice and hearing pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the board and approved by the commissioner.~~))

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.41 RCW to read as follows:

The board shall submit to the administrator a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The administrator shall, after notice and hearing pursuant to chapter 34.05 RCW, approve the plan of operation if it is determined to assure the fair, reasonable, and equitable administration of the pool and provides for the sharing of pool losses on an equitable, proportionate basis among the members of the pool. The plan of operation shall become effective upon approval in writing by the administrator consistent with the date on which the coverage under this chapter must be made available. If the board fails to submit acceptable amendments to the plan, the administrator shall, within ninety days after notice and hearing pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are necessary or advisable to effectuate this chapter. The rules shall continue in force until modified by the administrator or superseded by a plan submitted by the board and approved by the administrator.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.41 RCW to read as follows:

The board shall develop a plan of operation and submit it to the administrator as provided in section 5 of this act. The plan of operation shall:

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

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

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

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

(5) Establish a process to determine the amount of assessment pursuant to RCW 48.41.060, which shall occur after March 1st of each calendar year, and which shall be due and payable within thirty days of the receipt of the assessment notice, and make advance interim assessments as may be reasonable and necessary for interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year;

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

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

(8) Establish a standardized risk assessment method to determine enrollment in pool or individual coverage;

(9) Modify pool benefits, as necessary, and as permitted in this chapter;

(10) Establish levels and method of provider payment;

(11) 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;

(12) 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;

(13) 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 small group plan rating requirements under RCW 48.44.023 and 48.46.066; and

(14) Contain additional provisions necessary and proper for the execution of the powers and duties of the pool.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.41 RCW to read as follows:

(1) The administrator shall have the general powers and authority granted to members to offer or provide the health coverage defined under this title.

(2) The administrator shall perform or enter into contracts as necessary and proper to carry out the following duties:

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

(b) Establishing a premium billing procedure for collection of premiums from 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, distributing forms upon which submission shall be made, and evaluating the eligibility of each claim for payment by the pool; and

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

(d) Issuing on behalf of the pool policies of health coverage in accordance with the requirements of RCW 48.41.110 and this chapter;

(e) Assessing members of the pool in accordance with the provisions of this chapter and the plan of operation;

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

(g) Following the close of each accounting year, make a determination of net paid and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board.

(3) The administrator shall be reimbursed for costs incurred through assessments charged to members and administrative fees charged to covered persons. The reimbursement methodology shall be determined by a formula established by the board.

(4) In addition thereto, the administrator may:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter; and

(b) 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.

**Sec. 8.** RCW 48.41.090 and 1989 c 121 s 6 are each amended to read as follows:

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

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction((~~,~~)). The numerator of ((~~which~~)) the fraction equals that member's total number of resident insured persons, including spouse and dependents under the member's health plan and the number of resident insured persons covered under stop loss policies issued to self-insured employer plans minus the number of insured persons covered under individual policies or contracts in the state during the preceding calendar year((~~, and~~)). The denominator of ((~~which~~)) the fraction equals the total number of resident insured persons including spouses and dependents insured under all health plans, including employer purchased stop loss policies, in the state by pool members.

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

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

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

**Sec. 9.** RCW 48.41.100 and 1995 c 34 s 5 are each amended to read as follows:

(1) Until January 1, 2000, any individual person who is a resident of this state is eligible for coverage ((~~upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on health insurance, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one member within six months of the date of application. Evidence of rejection may be waived in accordance with rules adopted by the board~~)). After that date, any individual who is a resident of the state and who meets the criteria in the standardized risk assessment is eligible.

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

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

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

(c) Inmates of public institutions and persons whose benefits are duplicated under medical assistance or other public programs.

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

**Sec. 10.** RCW 48.41.110 and 1997 c 231 s 213 are each amended to read as follows:

(1) The pool ((~~is authorized to~~)) shall offer one or more managed care plans of coverage except in counties where adequate provider networks cannot be established. 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. The board shall develop an alternative benefit design for counties where no managed care networks are established. The design shall be similar to the managed care plans' covered services and out-of-pocket expenses. Covered persons enrolled in the pool on January 1, ((~~1997~~)) 2000, 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.

(a) 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)~~)) (i) 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)~~)) (ii) 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)~~)) (iii) 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, in the case of mental or nervous conditions, and rendered by a state certified chemical dependency program approved under chapter 70.96A RCW, in the case of alcohol, drug, or chemical dependency or abuse;

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

((~~(e)~~)) (v) 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)~~)) (vi) Services of a home health agency;

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

((~~(h)~~)) (viii) Oxygen;

((~~(i)~~)) (ix) Anesthesia services;

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

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

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

((~~(m)~~)) (xiii) 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)~~)) (xiv) Maternity care services, ((~~as provided in the managed care plan to be designed by the pool board of directors, and~~)) for which no preexisting condition waiting periods may apply;

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

((~~(p)~~)) (xvi) Hospice services;

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

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

(b) The board shall design a managed care plan of coverage that provides services similar to those contained in (a) of this subsection. The board is authorized to deviate from this benefit design if medically appropriate, cost-effective alternatives are or should become available. The board shall take benefit design into consideration when establishing rates under RCW 48.41.200.

(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. Reimbursement for network providers under the managed care plan of coverage may include but is not limited to such methodologies as resource based relative value fee schedules; capitation payments; diagnostic related group fee schedules; and other similar strategies including risk sharing arrangements.

(4) The pool benefit policy may contain benefit limitations, exceptions, and 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 plans approved by the insurance commissioner; however, no limitation, exception, or reduction may be 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. 11.** RCW 48.41.120 and 1989 c 121 s 8 are each amended to read as follows:

(1) Subject to the limitation provided in subsection (3) of this section, a pool policy offered in accordance with ((~~this chapter~~)) RCW 48.41.110(2)(a) shall impose a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

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

(3) The maximum aggregate out of pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance under a pool policy offered in accordance with RCW 48.41.110(2)(a) shall not exceed in a calendar year:

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

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

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

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

(5) A managed care plan of coverage issued in accordance with RCW 48.41.110(2)(b) shall employ point-of-service cost-sharing copayments for covered services, the amount to be determined by the board. In

establishing the amount of cost sharing, the board shall consider the cost-sharing amounts charged in other managed care products offered to employer sponsored groups in this state. The maximum annual out-of-pocket expenses shall not exceed three thousand five hundred dollars. These amounts may be revised from time to time by the board.

(6) The board may grant premium and cost sharing discounts of up to ten percent for persons enrolled in the pool for more than twelve months.

**Sec. 12.** RCW 48.43.015 and 1995 c 265 s 5 are each amended to read as follows:

(1) Every health carrier issuing group coverage shall waive any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different group or individual health plan at any time during the three-month period immediately preceding the date of application for the new health plan if such person was continuously covered under the immediately preceding health plan. If the person was continuously covered for at least three months under the immediately preceding group or individual health plan, the carrier may not impose a waiting period for coverage of preexisting conditions. If the person was continuously covered for less than three months under the immediately preceding group or individual health plan, the carrier must credit any waiting period under the immediately preceding health plan toward the new health plan. For the purposes of this subsection, a preceding health plan includes an employer provided self-funded health plan.

(2) Every carrier issuing individual coverage shall waive any preexisting condition exclusion or limitation for persons who had similar health coverage under a group health plan at any time during the three-month period immediately preceding the date of application for the new individual health plan if the person was continuously covered under the immediately preceding health plan. If the person was continuously covered for less than three months under the immediately preceding group health plan, the carrier must credit any waiting period under the immediately preceding health plan toward the new health plan. For the purposes of this subsection, health plan includes an employer provided self-funded plan.

(3) Every carrier issuing individual coverage shall waive any preexisting condition exclusion or limitation as follows:

(a) If the person has had individual health coverage for at least twelve months and is seeking coverage during the month in which the person enrolled in their existing individual health insurance coverage. In such a case, the person may purchase any coverage without being subject to coverage for existing conditions provisions;

(b) If the person is seeking coverage at a time other than the month the person enrolled in their previous individual health insurance coverage, the person may be subject to the coverage for existing conditions provisions established in this section but only for the benefits not covered in previous coverage; or

(c) If the person is leaving the previous coverage for good cause, as determined by the commissioner by rule, the person is eligible as set forth in (a) of this subsection.

(4) Subject to the provisions of subsection (1) of this section, nothing contained in this section requires a health carrier to amend a health plan to provide new benefits in its existing health plans. In addition, nothing in this section requires a carrier to waive benefit limitations not related to an individual or group's preexisting conditions or health history.

**Sec. 13.** RCW 48.43.025 and 1995 c 265 s 6 are each amended to read as follows:

(1) No carrier may reject an individual for health plan coverage based upon preexisting conditions of the individual and 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~~)) except as provided in subsection (2) of this section.

(2) Except as provided in RCW 48.43.015(3), upon application of an individual for individual coverage, other than medicare supplemental coverage provided under chapter 48.66 RCW, a carrier:

(a) Must screen the applicant through the standardized risk assessment process established under section 6 of this act, and if the individual exceeds the risk threshold, refer the applicant to the Washington state health insurance pool for pool coverage;

(b) May, if the applicant does not exceed the risk threshold, but has a condition for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a reasonable layperson would have sought advice or treatment within six months before the effective date of coverage, impose additional premiums for no more than twelve months in an amount not to exceed the following:

(i) A deductible of five hundred dollars;

(ii) Coinsurance of forty percent of eligible expenses; and

(iii) A maximum annual aggregate out-of-pocket expense of three thousand five hundred dollars.

(3) A person whose immediate prior coverage was through the Washington state health insurance pool must be screened as set forth in subsection (2) of this section before individual coverage eligibility.

(4) 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 provisions apply only to individuals who are Washington residents.

**Sec. 14.** RCW 70.47.060 and 1998 c 314 s 17 and 1998 c 148 s 1 are each reenacted and amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care

services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for groups of subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.47.030, and such other factors as the administrator deems appropriate.

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

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

(b) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative

cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201.

(c) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator.

(d) To develop, as an offering by every health carrier subject to RCW 48.44.023, 48.46.066, or 48.21.045 providing coverage identical to the basic health plan, as configured on January 1, 1996, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

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

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

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

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

(7) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make

suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

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

(9) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized or nonsubsidized enrollees, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish

appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

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

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

(12) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems,

including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

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

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

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

(16) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

(17) To permit any participating managed health care system to bid and contract for the subsidized basic health plan only.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.43 RCW to read as follows:

Every carrier that offers individual coverage shall offer and actively market to all individuals a health plan with benefits not less than those defined in RCW 70.47.060(2)(d). However, benefits must include medical rehabilitation and prescription drug benefits that are no less than those provided to public employees under chapter 41.05 RCW.

NEW SECTION. **Sec. 16.** A new section is added to chapter 48.41 RCW to read as follows:

The Washington state health pool coverage as presently constituted is opened to all applicants until January 1, 2000.

NEW SECTION. **Sec. 17.** A new section is added to chapter 48.41 RCW to read as follows:

Nothing in chapter . . ., Laws of 1999 (this act) affects, modifies, or terminates existing individual or group health plan coverage.

NEW SECTION. **Sec. 18.** The Washington state health insurance board shall develop a plan for feasibility and implementation of a reinsurance mechanism to be applied to the individual insurance market. The plan shall be submitted to the legislature by December 1, 2000.

NEW SECTION. **Sec. 19.** The following acts or parts of acts are each repealed:

(1) RCW 48.20.028 (Mandatory offering to individuals providing basic health plan benefits--Exemption from statutory requirements--Premium rates--Definitions) and 1997 c 231 s 207 & 1995 c 265 s 13;

(2) RCW 48.41.050 (Operation plan--Contents) and 1987 c 431 s 5;

(3) RCW 48.41.060 (Board powers) and 1997 c 337 s 5, 1997 c 231 s 211, 1989 c 121 s 3, & 1987 c 431 s 6;

(4) RCW 48.41.080 (Pool administrator--Selection, term, duties, pay) and 1997 c 231 s 212, 1989 c 121 s 5, & 1987 c 431 s 8;

(5) RCW 48.44.022 (Mandatory offering to individuals providing basic health plan benefits--Exemption from statutory requirements--Premium rates--Definitions) and 1997 c 231 s 208 & 1995 c 265 s 15; and

(6) RCW 48.46.064 (Mandatory offering to individuals providing basic health plan benefits--Exemption from statutory requirements--Premium rates--Definitions) and 1997 c 231 s 209 & 1995 c 265 s 17.

NEW SECTION. **Sec. 20.** Section 16 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 immediately.

**--- END ---**