H-5125.2

HOUSE BILL 3154

State of Washington 56th Legislature 2000 Regular Session

By Representatives Cody, Parlette, Conway, Clements, Campbell, Cairnes and Wood

Read first time 03/04/2000. Referred to Committee on .

1 AN ACT Relating to technical and clarifying corrections to chapter
2 . . . (Engrossed Second Substitute Senate Bill No. 6067), Laws of 2000;
3 amending RCW 48.41.040, 48.41.110, 48.43.015, 48.43.---, 41.05.140,
4 41.05.---, and 48.21.015; and adding a new section to chapter 43.33A
5 RCW.

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

7 **Sec. 1.** RCW 48.41.040 and 2000 c . . . (E2SSB 6067) s 7 are each
8 amended to read as follows:
9 (1) There is created a nonprofit entity to be known as the
10 Washington state health insurance pool. All members in this state on
11 or after May 18, 1987, shall be members of the pool. When authorized
12 by federal law, all self-insured employers shall also be members of the
13 pool.
14 (2) Pursuant to chapter 34.05 RCW the commissioner shall, within
15 ninety days after May 18, 1987, give notice to all members of the time
16 and place for the initial organizational meetings of the pool. A board
17 of directors shall be established, which shall be comprised of ten
18 members. The governor shall select one member of the board from each
19 list of three nominees submitted by state-wide organizations

1 representing each of the following: (a) Health care providers; (b)
2 health insurance agents; (c) small employers; and (d) large employers.
3 The governor shall select two members of the board from a list of
4 nominees submitted by state-wide organizations representing health care
5 consumers. In making these selections, the governor may request
6 additional names from the state-wide organizations representing each of
7 the persons to be selected if the governor chooses not to select a
8 member from the list submitted. The remaining four members of the
9 board shall be selected by election from among the members of the pool.
10 The elected members shall, to the extent possible, include at least one
11 representative of health care service contractors, one representative
12 of health maintenance organizations, and one representative of
13 commercial insurers which provides disability insurance. The members
14 of the board shall elect a chair from the voting members of the board.
15 The insurance commissioner shall be a nonvoting, ex officio member.
16 When self-insured organizations other than the Washington state health
17 care authority become eligible for participation in the pool, the
18 membership of the board shall be increased to eleven and at least one
19 member of the board shall represent the self-insurers.

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

25 (4) The board shall submit to the commissioner a plan of operation
26 for the pool and any amendments thereto necessary or suitable to assure
27 the fair, reasonable, and equitable administration of the pool. The
28 commissioner shall, after notice and hearing pursuant to chapter 34.05
29 RCW, approve the plan of operation if it is determined to assure the
30 fair, reasonable, and equitable administration of the pool and provides
31 for the sharing of pool losses on an equitable, proportionate basis
32 among the members of the pool. The plan of operation shall become
33 effective upon approval in writing by the commissioner consistent with
34 the date on which the coverage under this chapter must be made
35 available. If the board fails to submit a plan of operation within one
36 hundred eighty days after the appointment of the board or any time
37 thereafter fails to submit acceptable amendments to the plan, the
38 commissioner shall, within ninety days after notice and hearing
39 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.

Sec. 2. RCW 48.41.110 and 2000 c . . . (E2SSB 6067) s 13 are each amended to read as follows:

(1) The pool shall offer one or more care management 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, 2001, 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, such brochure shall be made reasonably available to participants or potential participants.

(3) The health insurance policy issued by the pool shall pay only reasonable amounts 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 reasonable amounts 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, 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) 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 services;

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

(p) Hospice services;

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

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

1 (4) The board shall design and employ cost containment measures and
2 requirements such as, but not limited to, care coordination, provider
3 network limitations, preadmission certification, and concurrent
4 inpatient review which may make the pool more cost-effective.
5 (5) The pool benefit policy may contain benefit limitations,
6 exceptions, and cost shares such as copayments, coinsurance, and
7 deductibles that are consistent with managed care products, except that
8 differential cost shares may be adopted by the board for nonnetwork
9 providers under point of service plans. The pool benefit policy cost
10 shares and limitations must be consistent with those that are generally
11 included in health plans approved by the insurance commissioner;
12 however, no limitation, exception, or reduction may be used that would
13 exclude coverage for any disease, illness, or injury.
14 (6) The pool may not reject an individual for health plan coverage
15 based upon preexisting conditions of the individual or deny, exclude,
16 or otherwise limit coverage for an individual's preexisting health
17 conditions; except that it shall impose a six-month benefit waiting
18 period for preexisting conditions for which medical advice was given,
19 for which a health care provider recommended or provided treatment, or
20 for which a prudent layperson would have sought advice or treatment,
21 within six months before the effective date of coverage. The
22 preexisting condition waiting period shall not apply to prenatal care
23 services. The pool may not avoid the requirements of this section
24 through the creation of a new rate classification or the modification
25 of an existing rate classification. Credit against the waiting period
26 shall be as provided in subsection (7) of this section.
27 (7)(a) Except as provided in (b) of this subsection, the pool shall
28 credit any preexisting condition waiting period in its plans for a
29 person who was enrolled at any time during the sixty-three day period
30 immediately preceding the date of application for the new pool plan in
31 a group health benefit plan or an individual health benefit plan other
32 than a catastrophic health plan. The ((~~carrier~~)) pool must credit the
33 period of coverage the person was continuously covered under the
34 immediately preceding health plan toward the waiting period of the new
35 health plan. For the purposes of this subsection, a preceding health
36 plan includes an employer-provided self-funded health plan.
37 (b) The pool shall waive any preexisting condition waiting period
38 for a person who is an eligible individual as defined in section

1 2741(b) of the federal health insurance portability and accountability
2 act of 1996 (42 U.S.C. 300gg-41(b)).

3 **Sec. 3.** RCW 48.43.015 and 2000 c . . . (E2SSB 6067) s 20 are each
4 amended to read as follows:
5 (1) For a health benefit plan offered to a group other than a small
6 group, every health carrier shall reduce any preexisting condition
7 exclusion or limitation for persons or groups who had similar health
8 coverage under a different health plan at any time during the three-
9 month period immediately preceding the date of application for the new
10 health plan if such person was continuously covered under the
11 immediately preceding health plan. If the person was continuously
12 covered for at least three months under the immediately preceding
13 health plan, the carrier may not impose a waiting period for coverage
14 of preexisting conditions. If the person was continuously covered for
15 less than three months under the immediately preceding health plan, the
16 carrier must credit any waiting period under the immediately preceding
17 health plan toward the new health plan. For the purposes of this
18 subsection, a preceding health plan includes an employer provided self-
19 funded health plan and plans of the Washington state health insurance
20 pool.
21 (2) For a health benefit plan offered to a small group, every
22 health carrier shall reduce any preexisting condition exclusion or
23 limitation for persons or groups who had similar health coverage under
24 a different health plan at any time during the three-month period
25 immediately preceding the date of application for the new health plan
26 if such person was continuously covered under the immediately preceding
27 health plan. If the person was continuously covered for at least nine
28 months under the immediately preceding health plan, the carrier may not
29 impose a waiting period for coverage of preexisting conditions. If the
30 person was continuously covered for less than nine months under the
31 immediately preceding health plan, the carrier must credit any waiting
32 period under the immediately preceding health plan toward the new
33 health plan. For the purposes of this subsection, a preceding health
34 plan includes an employer provided self-funded health plan and plans of
35 the Washington state health insurance pool.
36 (3) For a health benefit plan offered to an individual, other than
37 an individual to whom subsection (4) of this section applies, every
38 health carrier shall credit any preexisting condition waiting period in

1 that plan for a person who was enrolled at any time during the sixty-
2 three day period immediately preceding the date of application for the
3 new health plan in a group health benefit plan or an individual health
4 benefit plan, other than a catastrophic health plan, and (a) the
5 benefits under the previous plan provide equivalent or greater overall
6 benefit coverage than that provided in the health benefit plan the
7 individual seeks to purchase; or (b) the person is seeking an
8 individual health benefit plan due to his or her change of residence
9 from one geographic area in Washington state to another geographic area
10 in Washington state where his or her current health plan is not
11 offered, if application for coverage is made within ninety days of
12 relocation; or (c) the person is seeking an individual health benefit
13 plan: (i) Because a health care provider with whom he or she has an
14 established care relationship and from whom he or she has received
15 treatment within the past twelve months is no longer part of the
16 carrier's provider network under his or her existing Washington
17 individual health benefit plan; and (ii) his or her health care
18 provider is part of another carrier's provider network; and (iii)
19 application for a health benefit plan under that carrier's provider
20 network individual coverage is made within ninety days of his or her
21 provider leaving the previous carrier's provider network. The carrier
22 must credit the period of coverage the person was continuously covered
23 under the immediately preceding health plan toward the waiting period
24 of the new health plan. For the purposes of this subsection (3), a
25 preceding health plan includes an employer-provided self-funded health
26 plan and plans of the Washington state health insurance pool.
27 (4) Every health carrier shall waive any preexisting condition
28 waiting period in its individual plans for a person who is an eligible
29 individual as defined in section 2741(b) of the federal health
30 insurance portability and accountability act of 1996 (42 U.S.C. 300gg-
31 41(b)).
32 (5) Subject to the provisions of subsections (1) through ((~~(3)~~))
33 (4) of this section, nothing contained in this section requires a
34 health carrier to amend a health plan to provide new benefits in its
35 existing health plans. In addition, nothing in this section requires
36 a carrier to waive benefit limitations not related to an individual or
37 group's preexisting conditions or health history.

Sec. 4. RCW 48.43.--- and 2000 c . . . (E2SSB 6067) s 21 are each amended to read as follows:

(1) Except as provided in (a) ((~~and (b)~~)) through (c) of this subsection, a health carrier may require any person applying for an individual health benefit plan to complete the standard health questionnaire designated under chapter 48.41 RCW.

(a) If a person is seeking an individual health benefit plan due to his or her change of residence from one geographic area in Washington state to another geographic area in Washington state where his or her current health plan is not offered, completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of relocation.

(b) If a person is seeking an individual health benefit plan:

(i) Because a health care provider with whom he or she has an established care relationship and from whom he or she has received treatment within the past twelve months is no longer part of the carrier's provider network under his or her existing Washington individual health benefit plan; and

(ii) His or her health care provider is part of another carrier's provider network; and

(iii) Application for a health benefit plan under that carrier's provider network individual coverage is made within ninety days of his or her provider leaving the previous carrier's provider network; then completion of the standard health questionnaire shall not be a condition of coverage.

(c) If a person is seeking an individual health benefit plan due to his or her having exhausted continuation coverage provided under 29 U.S.C. Sec. 1161 et seq., completion of the standard health questionnaire shall not be a condition of coverage if application for coverage is made within ninety days of exhaustion of continuation coverage.

(2) If, based upon the results of the standard health questionnaire, the person qualifies for coverage under the Washington state health insurance pool, the following shall apply:

(a) The carrier may decide not to accept the person's application for enrollment in its individual health benefit plan; and

(b) Within fifteen business days of receipt of a completed application, the carrier shall provide written notice of the decision not to accept the person's application for enrollment to both the

1 person and the administrator of the Washington state health insurance
2 pool. The notice to the person shall state that the person is eligible
3 for health insurance provided by the Washington state health insurance
4 pool, and shall include information about the Washington state health
5 insurance pool and an application for such coverage.
6 (3) If the person applying for an individual health benefit plan:
7 (a) Does not qualify for coverage under the Washington state health
8 insurance pool based upon the results of the standard health
9 questionnaire; (b) does qualify for coverage under the Washington state
10 health insurance pool based upon the results of the standard health
11 questionnaire and the carrier elects to accept the person for
12 enrollment; or (c) is not required to complete the standard health
13 questionnaire designated under this chapter under subsection (1)(a) or
14 (b) of this section, the carrier shall accept the person for enrollment
15 if he or she resides within the carrier's service area and provide or
16 assure the provision of all covered services regardless of age, sex,
17 family structure, ethnicity, race, health condition, geographic
18 location, employment status, socioeconomic status, other condition or
19 situation, or the provisions of RCW 49.60.174(2). The commissioner may
20 grant a temporary exemption from this subsection if, upon application
21 by a health carrier, the commissioner finds that the clinical,
22 financial, or administrative capacity to serve existing enrollees will
23 be impaired if a health carrier is required to continue enrollment of
24 additional eligible individuals.

25 **Sec. 5.** RCW 41.05.140 and 2000 c . . . (E2SSB 6067) s 44 are each
26 amended to read as follows:
27 (1) Except for property and casualty insurance, the authority may
28 self-fund, self-insure, or enter into other methods of providing
29 insurance coverage for insurance programs under its jurisdiction,
30 including the basic health plan as provided in chapter 70.47 RCW. The
31 authority shall contract for payment of claims or other administrative
32 services for programs under its jurisdiction. If a program does not
33 require the prepayment of reserves, the authority shall establish such
34 reserves within a reasonable period of time for the payment of claims
35 as are normally required for that type of insurance under an insured
36 program. The authority shall endeavor to reimburse basic health plan
37 health care providers under this section at rates similar to the

average reimbursement rates offered by the state-wide benchmark plan determined through the request for proposal process.

(2) Reserves established by the authority for employee and retiree benefit programs shall be held in a separate trust fund by the state treasurer and shall be known as the public employees' and retirees' insurance reserve fund. The state investment board shall act as the investor for the funds and, except as provided in RCW 43.33A.160 and 43.84.160, one hundred percent of all earnings from these investments shall accrue directly to the public employees' and retirees' insurance reserve fund.

(3) Any savings realized as a result of a program created for employees and retirees under this section shall not be used to increase benefits unless such use is authorized by statute.

(4) Reserves established by the authority to provide insurance coverage for the basic health plan under chapter 70.47 RCW shall be held in a separate trust account in the custody of the state treasurer and shall be known as the basic health plan self-insurance reserve account. The state investment board shall act as the investor for the funds ((~~and, except as provided in RCW 43.33A.160~~)) as set forth in section 6 of this act and, except as provided in RCW 43.33A.160 and 43.84.160, one hundred percent of all earnings from these investments shall accrue directly to the basic health plan self-insurance reserve account.

(5) Any program created under this section shall be subject to the examination requirements of chapter 48.03 RCW as if the program were a domestic insurer. In conducting an examination, the commissioner shall determine the adequacy of the reserves established for the program.

(6) The authority shall keep full and adequate accounts and records of the assets, obligations, transactions, and affairs of any program created under this section.

(7) The authority shall file a quarterly statement of the financial condition, transactions, and affairs of any program created under this section in a form and manner prescribed by the insurance commissioner. The statement shall contain information as required by the commissioner for the type of insurance being offered under the program. A copy of the annual statement shall be filed with the speaker of the house of representatives and the president of the senate.

1 <u>NEW SECTION.</u> **Sec. 6.** A new section is added to chapter 43.33A RCW
2 to read as follows:
3 (1) The state investment board has the full power to invest,
4 reinvest, manage, contract, sell, or exchange investment money in the
5 basic health plan self-insurance reserve account. All investment and
6 operating costs associated with the investment of money shall be paid
7 under RCW 43.33A.160 and 43.84.160. With the exception of these
8 expenses, the earnings from the investment of the money shall be
9 retained by the account.
10 (2) All investments made by the state investment board shall be
11 made with the exercise of that degree of judgment and care under RCW
12 43.33A.140 and the investment policy established by the state
13 investment board.
14 (3) As deemed appropriate by the investment board, money in the
15 account may be commingled for investment with other funds subject to
16 investment by the board.
17 (4) The investment board shall routinely consult and communicate
18 with the health care authority on the investment policy, earnings of
19 the account, and related needs of the account.

20 **Sec. 7.** RCW 41.05.--- and 2000 c . . . (E2SSB 6067) s 46 are each
21 amended to read as follows:
22 (1) The administrator shall design and offer a plan of health care
23 coverage as described in subsection (2) of this section, for any person
24 eligible under subsection (3) of this section. The health care
25 coverage shall be designed and offered only to the extent that state
26 funds are specifically appropriated for this purpose.
27 (2) The plan of health care coverage shall have the following
28 components:
29 (a) Services covered more limited in scope than those contained in
30 RCW 48.41.110(3);
31 (b) Enrollee cost-sharing that may include but not be limited to
32 point-of-service cost-sharing for covered services;
33 (c) Deductibles of three thousand dollars on a per person per
34 calendar year basis, and four thousand dollars on a per family per
35 calendar year basis. The deductible shall be applied to the first
36 three thousand dollars, or four thousand dollars, of eligible expenses
37 incurred by the covered person or family, respectively, except that the
38 deductible shall not be applied to clinical preventive services as

recommended by the United States public health service. Enrollee out-of-pocket expenses required to be paid under the plan for cost-sharing and deductibles shall not exceed five thousand dollars per person, or six thousand dollars per family;

(d) Payment methodologies for network providers may include but are not limited to resource-based relative value fee schedules, capitation payments, diagnostic related group fee schedules, and other similar strategies including risk-sharing arrangements; and

(e) Other appropriate care management and cost-containment measures determined appropriate by the administrator, including but not limited to care coordination, provider network limitations, preadmission certification, and utilization review.

(3) Any person is eligible for coverage in the plan who resides in a county of the state where no carrier, as defined in RCW 48.43.005, or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan as defined in RCW 48.43.005 other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the administrator. Such eligibility may terminate pursuant to subsection ((~~(7)~~)) (8) of this section.

(4) The administrator may not reject an individual for 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 shall impose a nine-month benefit waiting period for preexisting conditions for which medical advice was given, or for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services. Credit against the waiting period shall be provided pursuant to subsections (5) and (6) of this section.

(5) Except for persons to whom subsection (6) of this section applies, the administrator shall credit any preexisting condition waiting period in the plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the plan in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan. The administrator must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this

1 subsection, a preceding health plan includes an employer-provided self-
2 funded health plan.
3 (6) The administrator shall waive any preexisting condition waiting
4 period in the plan for a person who is an eligible individual as
5 defined in section 2741(b) of the federal health insurance portability
6 and accountability act of 1996 (42 U.S.C. 300gg-41(b)).
7 (7) The administrator shall set the rates to be charged plan
8 enrollees.
9 ((~~(7)~~)) (8) When a carrier, as defined in RCW 48.43.005, or an
10 insurer regulated under chapter 48.15 RCW, begins to offer an
11 individual health benefit plan as defined in RCW 48.43.005 in a county
12 where no carrier or insurer had been offering an individual health
13 benefit plan:
14 (a) If the health benefit plan offered is other than a catastrophic
15 health plan as defined in RCW 48.43.005, any person enrolled in the
16 plan under subsection (3) of this section in that county shall no
17 longer be eligible;
18 (b) The administrator shall provide written notice to any person
19 who is no longer eligible for coverage under the plan within thirty
20 days of the administrator's determination that the person is no longer
21 eligible. The notice shall: (i) Indicate that coverage under the plan
22 will cease ninety days from the date that the notice is dated; (ii)
23 describe any other coverage options available to the person; and (iii)
24 describe the enrollment process for the available options.

25 **Sec. 8.** RCW 48.21.015 and 1992 c 226 s 3 are each amended to read
26 as follows:
27 Group stop loss insurance is exempt from all sections of this
28 chapter((~~,~~)) and chapter 48.32A RCW((~~, and chapter 48.41 RCW~~)) except
29 for RCW 48.21.010 and this section. For ((~~[the]~~)) the purpose of this
30 exemption, group stop loss is further defined as follows:
31 (1) The policy must be issued to and insure the employer, the
32 trustee or other sponsor of the plan, or the plan itself, but not the
33 employees, members, or participants;
34 (2) Payment by the insurer must be made to the employer, the
35 trustee, or other sponsor of the plan or the plan itself, but not to
36 the employees, members, participants, or health care providers;

1 (3) The policy must contain a provision that establishes an
2 aggregate attaching point or retention that is at the minimum one
3 hundred twenty percent of the expected claims; and
4 (4) The policy may provide for an individual attaching point or
5 retention that is not less than five percent of the expected claims or
6 one hundred thousand dollars, whichever is less.

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