CERTIFICATION OF ENROLLMENT

HOUSE BILL 3154

56th Legislature
2000 Regular Session

Passed by the House March 4, 2000
Yeas 96 Nays 0

Speaker of the House of Representatives

Speaker of the House of Representatives

Passed by the Senate March 6, 2000
Yeas 43 Nays 1

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

We, Timothy A. Martin and Cynthia Zehnder, Co-Chief Clerks of the House of Representatives of the State of Washington, do hereby certify that the attached is **HOUSE BILL 3154** as passed by the House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

Chief Clerk

FILED

Secretary of State
State of Washington

HOUSE BILL 3154

Passed Legislature - 2000 Regular Session

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 .

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

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

Sec. 1. RCW 48.41.040 and 2000 c . . . (E2SSB 6067) s 7 are each amended to read as follows:

(1) There is 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 ten members. The governor shall select one member of the board from each list of three nominees submitted by state-wide organizations

representing each of the following: (a) Health care providers; (b) health insurance agents; (c) small employers; and (d) large employers. The governor shall select two members of the board from a list of nominees submitted by state-wide organizations representing health care consumers. In making these selections, the governor may request additional names from the state-wide organizations representing each of the persons to be selected if the governor chooses not to select a member from the list submitted. The remaining four 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. The members of the board shall elect a chair from the voting members of the board. The insurance commissioner shall be a nonvoting, ex officio member. When self-insured organizations other than the Washington state health care authority 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.

(3) The original 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.

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.

(4) 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.

(5) 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.

(6) 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 shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, 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. 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. Credit against the waiting period shall be as provided in subsection (7) of this section.

(7)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan. The ((~~carrier~~)) pool 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 subsection, a preceding health plan includes an employer-provided self-funded health plan.

(b) The pool shall waive any preexisting condition waiting period for a person who is an eligible individual as defined in section

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

Sec. 3. RCW 48.43.015 and 2000 c . . . (E2SSB 6067) s 20 are each amended to read as follows:

(1) For a health benefit plan offered to a group other than a small group, every health carrier shall reduce any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different 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 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 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 and plans of the Washington state health insurance pool.

(2) For a health benefit plan offered to a small group, every health carrier shall reduce any preexisting condition exclusion or limitation for persons or groups who had similar health coverage under a different 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 nine months under the immediately preceding health plan, the carrier may not impose a waiting period for coverage of preexisting conditions. If the person was continuously covered for less than nine months under the immediately preceding 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 and plans of the Washington state health insurance pool.

(3) For a health benefit plan offered to an individual, other than an individual to whom subsection (4) of this section applies, every health carrier shall credit any preexisting condition waiting period in

that plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new health plan in a group health benefit plan or an individual health benefit plan, other than a catastrophic health plan, and (a) the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the health benefit plan the individual seeks to purchase; or (b) the 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, if application for coverage is made within ninety days of relocation; or (c) the 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. The carrier 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 subsection (3), a preceding health plan includes an employer-provided self-funded health plan and plans of the Washington state health insurance pool.

(4) Every health carrier shall waive any preexisting condition waiting period in its individual plans for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(5) Subject to the provisions of subsections (1) through ((~~(3)~~)) (4) 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. 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

person and the administrator of the Washington state health insurance pool. The notice to the person shall state that the person is eligible for health insurance provided by the Washington state health insurance pool, and shall include information about the Washington state health insurance pool and an application for such coverage.

(3) If the person applying for an individual health benefit plan: (a) Does not qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire; (b) does qualify for coverage under the Washington state health insurance pool based upon the results of the standard health questionnaire and the carrier elects to accept the person for enrollment; or (c) is not required to complete the standard health questionnaire designated under this chapter under subsection (1)(a) or (b) of this section, the carrier shall accept the person for enrollment if he or she resides 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 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.

Sec. 5. RCW 41.05.140 and 2000 c . . . (E2SSB 6067) s 44 are each amended to read as follows:

(1) Except for property and casualty insurance, the authority may self-fund, self-insure, or enter into other methods of providing insurance coverage for insurance programs under its jurisdiction, including the basic health plan as provided in chapter 70.47 RCW. The authority shall contract for payment of claims or other administrative services for programs under its jurisdiction. If a program does not require the prepayment of reserves, the authority shall establish such reserves within a reasonable period of time for the payment of claims as are normally required for that type of insurance under an insured program. The authority shall endeavor to reimburse basic health plan 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.

NEW SECTION. **Sec. 6.** A new section is added to chapter 43.33A RCW to read as follows:

(1) The state investment board has the full power to invest, reinvest, manage, contract, sell, or exchange investment money in the basic health plan self-insurance reserve account. All investment and operating costs associated with the investment of money shall be paid under RCW 43.33A.160 and 43.84.160. With the exception of these expenses, the earnings from the investment of the money shall be retained by the account.

(2) All investments made by the state investment board shall be made with the exercise of that degree of judgment and care under RCW 43.33A.140 and the investment policy established by the state investment board.

(3) As deemed appropriate by the investment board, money in the account may be commingled for investment with other funds subject to investment by the board.

(4) The investment board shall routinely consult and communicate with the health care authority on the investment policy, earnings of the account, and related needs of the account.

Sec. 7. RCW 41.05.--- and 2000 c . . . (E2SSB 6067) s 46 are each amended to read as follows:

(1) The administrator shall design and offer a plan of health care coverage as described in subsection (2) of this section, for any person eligible under subsection (3) of this section. The health care coverage shall be designed and offered only to the extent that state funds are specifically appropriated for this purpose.

(2) The plan of health care coverage shall have the following components:

(a) Services covered more limited in scope than those contained in RCW 48.41.110(3);

(b) Enrollee cost-sharing that may include but not be limited to point-of-service cost-sharing for covered services;

(c) Deductibles of three thousand dollars on a per person per calendar year basis, and four thousand dollars on a per family per calendar year basis. The deductible shall be applied to the first three thousand dollars, or four thousand dollars, of eligible expenses incurred by the covered person or family, respectively, except that the 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

subsection, a preceding health plan includes an employer-provided self-funded health plan.

(6) The administrator shall waive any preexisting condition waiting period in the plan for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(7) The administrator shall set the rates to be charged plan enrollees.

((~~(7)~~)) (8) When a carrier, as defined in RCW 48.43.005, or an insurer regulated under chapter 48.15 RCW, begins to offer an individual health benefit plan as defined in RCW 48.43.005 in a county where no carrier or insurer had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in the plan under subsection (3) of this section in that county shall no longer be eligible;

(b) The administrator shall provide written notice to any person who is no longer eligible for coverage under the plan within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options available to the person; and (iii) describe the enrollment process for the available options.

Sec. 8. RCW 48.21.015 and 1992 c 226 s 3 are each amended to read as follows:

Group stop loss insurance is exempt from all sections of this chapter((~~,~~)) and chapter 48.32A RCW((~~, and chapter 48.41 RCW~~)) except for RCW 48.21.010 and this section. For ((~~[the]~~)) the purpose of this exemption, group stop loss is further defined as follows:

(1) The policy must be issued to and insure the employer, the trustee or other sponsor of the plan, or the plan itself, but not the employees, members, or participants;

(2) Payment by the insurer must be made to the employer, the trustee, or other sponsor of the plan or the plan itself, but not to the employees, members, participants, or health care providers;

(3) The policy must contain a provision that establishes an aggregate attaching point or retention that is at the minimum one hundred twenty percent of the expected claims; and

(4) The policy may provide for an individual attaching point or retention that is not less than five percent of the expected claims or one hundred thousand dollars, whichever is less.

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