ENGROSSED SUBSTITUTE HOUSE BILL 2540

State of Washington 59th Legislature 2006 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Schual-Berke and Morrell)

READ FIRST TIME 1/31/06.

AN ACT Relating to access to individual health insurance coverage; amending RCW 48.41.100, 48.41.110, 48.41.160, 48.41.190, 48.43.005, and 48.43.041; and providing an effective date.

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

Sec. 1. RCW 48.41.100 and 2001 c 196 s 3 are each amended to read as follows:

(1) The following persons who are residents of this state are eligible for pool coverage:

(a) Any person who provides evidence of a carrier's decision not to accept him or her for enrollment in an individual health benefit plan as defined in RCW 48.43.005 based upon, and within ninety days of the receipt of, the results of the standard health questionnaire designated by the board and administered by health carriers under RCW 48.43.018;

(b) Any person who continues to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator pursuant to subsection (3) of this section;

(c) Any person who resides in a county of the state where no carrier or insurer eligible under chapter 48.15 RCW offers to the

public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool, and who makes direct application to the pool; and

(d) Any medicare eligible person upon providing evidence of rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on a medicare supplemental insurance policy under chapter 48.66 RCW, 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.

(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. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

(c) Inmates of public institutions and persons whose benefits are duplicated under public programs. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(d) Any person who resides in a county of the state where any carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool and who does not qualify for pool coverage based upon the results of the standard health questionnaire, or pursuant to subsection (1)(d) of this section.

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county where no carrier 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 a pool

plan pursuant to subsection (1)(c) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(c) of this section, but may continue to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator. The pool administrator shall offer to administer the questionnaire to each person no longer eligible for coverage under subsection (1)(c) of this section within thirty days of determining that he or she is no longer eligible;

(b) Losing eligibility for pool coverage under this subsection (3) does not affect a person's eligibility for pool coverage under subsection (1)(a), (b), or (d) of this section; and

(c) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) 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, either in or outside of the pool, available to the person; (iii) describe the procedures for the administration of the standard health questionnaire to determine the person's continued eligibility for coverage under subsection (1)(b) of this section; and (iv) describe the enrollment process for the available options outside of the pool.

Sec. 2. RCW 48.41.110 and 2001 c 196 s 4 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 benefit policy shall be explicitly designed to identify pool enrollees with one or more chronic health conditions, and to provide appropriate, cost-effective care addressing their needs, including the integration of evidence-based chronic care service

delivery models into primary care protocols, innovative treatment delivery methods, and support for enrollee self-management.

(7) 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)~~)) (8) of this section.

((~~(7)~~)) (8)(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. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the 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)).

((~~(8)~~)) (9) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

Sec. 3. RCW 48.41.160 and 1987 c 431 s 16 are each amended to read as follows:

(1) A pool policy offered under this chapter shall contain provisions under which the pool is obligated to renew the policy until the day on which the individual in whose name the policy is issued first becomes eligible for medicare coverage. At that time, coverage of dependents shall terminate if such dependents are eligible for coverage under a different health plan. Dependents who become eligible for medicare prior to the individual in whose name the policy is issued, shall receive benefits in accordance with RCW 48.41.150.

(2) The pool may not change the rates for pool policies except on a class basis, with a clear disclosure in the policy of the pool's right to do so.

(3) A pool policy offered under this chapter shall provide that, upon the death of the individual in whose name the policy is issued, every other individual then covered under the policy may elect, within a period specified in the policy, to continue coverage under the same or a different policy.

(4) During December of each year, any person enrolled in a pool policy, other than the medical supplement policy offered under RCW 48.41.150, may move to any other pool policy, other than the medical supplement policy, with an equal or greater deductible. Any person enrolled in a pool policy may move to the medical supplement policy offered under RCW 48.41.150 when he or she enrolls in medicare.

Sec. 4. RCW 48.41.190 and 1989 c 121 s 10 are each amended to read as follows:

((~~Neither the participation by members, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by this chapter or the state of Washington shall be the basis of any legal action, civil or criminal liability or penalty against the pool, any member of the board of directors, or members of the pool either jointly or separately.~~)) The pool, members of the pool, board directors of the pool, officers of the pool, employees of the pool, the commissioner, the commissioner's representatives, and the commissioner's employees shall not be civilly or criminally liable and shall not have any penalty or cause of action of any nature arise against them for any action taken or not taken,

including any discretionary decision or failure to make a discretionary decision, when the action or inaction is done in good faith and in the performance of the powers and duties under this chapter. However, nothing in this section prohibits legal actions against the pool to enforce the pool's statutory or contractual duties and obligations.

Sec. 5. RCW 48.43.005 and 2004 c 244 s 2 are each amended to read as follows:

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

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

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

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

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

(5) "Catastrophic health plan" means:

(a) In the case of a contract, agreement, or policy covering a single enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, one thousand ((~~five~~)) seven hundred fifty dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least three thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; and

(b) In the case of a contract, agreement, or policy covering more than one enrollee, a health benefit plan requiring a calendar year deductible of, at a minimum, three thousand five hundred dollars and an annual out-of-pocket expense required to be paid under the plan (other than for premiums) for covered benefits of at least ((~~five~~)) six thousand five hundred dollars, both amounts to be adjusted annually by the insurance commissioner; or

(c) Any health benefit plan that provides benefits for hospital inpatient and outpatient services, professional and prescription drugs provided in conjunction with such hospital inpatient and outpatient services, and excludes or substantially limits outpatient physician services and those services usually provided in an office setting.

On September 1, 2006, and on each September 1st thereafter, the insurance commissioner shall adjust the minimum deductible and out-of-pocket expense required for a plan to qualify as a catastrophic plan to reflect the percentage change in the consumer price index for medical care for the preceding twelve months, as determined by the United States department of labor. The adjusted amounts shall apply on the following January 1st.

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

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

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

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

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

pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

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

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

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

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

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

(16) "Health care provider" or "provider" means:

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

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

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

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

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

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

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

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

(d) Disability income;

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

(f) Workers' compensation coverage;

(g) Accident only coverage;

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

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

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(20) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

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

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

(23) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

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

sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year except for a self-employed individual or sole proprietor in an agricultural trade or business, who must derive at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year. A self-employed individual or sole proprietor who is covered as a group of one on the day prior to June 10, 2004, shall also be considered a "small employer" to the extent that individual or group of one is entitled to have his or her coverage renewed as provided in RCW 48.43.035(6).

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

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

Sec. 6. RCW 48.43.041 and 2000 c 79 s 26 are each amended to read as follows:

(1) All individual health benefit plans, other than catastrophic health plans, offered or renewed on or after October 1, 2000, shall include benefits described in this section. Nothing in this section shall be construed to require a carrier to offer an individual health benefit plan.

(a) Maternity services that include, with no enrollee cost-sharing requirements beyond those generally applicable cost-sharing requirements: Diagnosis of pregnancy; prenatal care; delivery; care for complications of pregnancy; physician services; hospital services;

operating or other special procedure rooms; radiology and laboratory services; appropriate medications; anesthesia; and services required under RCW 48.43.115; and

(b) Prescription drug benefits with at least a two thousand five hundred dollar benefit payable by the carrier annually, to be increased by no less than one hundred dollars on January 1st of each year.

(2) If a carrier offers a health benefit plan that is not a catastrophic health plan to groups, and it chooses to offer a health benefit plan to individuals, it must offer at least one health benefit plan to individuals that is not a catastrophic health plan.

NEW SECTION. **Sec. 7.** This act takes effect January 1, 2007.

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