
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.

1 AN ACT Relating to access to individual health insurance coverage;
2 amending RCW 48.41.040, 48.41.060, 48.41.100, 48.41.110, 48.41.160,
3 48.41.190, 48.43.005, 48.43.018, and 48.43.041; and providing an
4 effective date.

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

6 **Sec. 1.** RCW 48.41.040 and 2000 c 80 s 1 are each amended to read
7 as follows:

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

13 (2) Pursuant to chapter 34.05 RCW the commissioner shall, within
14 ninety days after May 18, 1987, give notice to all members of the time
15 and place for the initial organizational meetings of the pool. A board
16 of directors shall be established, which shall be comprised of ten
17 members. The governor shall select one member of the board from each
18 list of three nominees submitted by statewide organizations
19 representing each of the following: (a) Health care providers; (b)

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

1 pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are
2 necessary or advisable to effectuate this chapter. The rules shall
3 continue in force until modified by the commissioner or superseded by
4 a plan submitted by the board and approved by the commissioner.

5 **Sec. 2.** RCW 48.41.060 and 2005 c 7 s 2 are each amended to read as
6 follows:

7 (1) The board shall have the general powers and authority granted
8 under the laws of this state to insurance companies, health care
9 service contractors, and health maintenance organizations, licensed or
10 registered to offer or provide the kinds of health coverage defined
11 under this title. In addition thereto, the board shall:

12 (a) Designate or establish the standard health questionnaire to be
13 used under RCW 48.41.100 and 48.43.018, including the form and content
14 of the standard health questionnaire and the method of its application.
15 The questionnaire must provide for an objective evaluation of an
16 individual's health status by assigning a discreet measure, such as a
17 system of point scoring to each individual. The questionnaire must not
18 contain any questions related to pregnancy, and pregnancy shall not be
19 a basis for coverage by the pool. The questionnaire shall be designed
20 such that it is reasonably expected to identify the eight percent of
21 persons who are the most costly to treat who are under individual
22 coverage in health benefit plans, as defined in RCW 48.43.005, in
23 Washington state or are covered by the pool, if applied to all such
24 persons;

25 (b) Obtain from a member of the American academy of actuaries, who
26 is independent of the board, a certification that the standard health
27 questionnaire meets the requirements of (a) of this subsection;

28 (c) Approve the standard health questionnaire and any modifications
29 needed to comply with this chapter. The standard health questionnaire
30 shall be submitted to an actuary for certification, modified as
31 necessary, and approved at least every eighteen months. The
32 designation and approval of the standard health questionnaire by the
33 board shall (~~not~~) be subject to review and approval by the
34 commissioner. The standard health questionnaire or any modification
35 thereto shall not be used until ninety days after public notice of the
36 commissioner's approval of the questionnaire or any modification

1 thereto, except that the initial standard health questionnaire approved
2 for use by the board after March 23, 2000, may be used immediately
3 following public notice of such approval;

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

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

19 (ii) Self-funded multiple employer welfare arrangements are subject
20 to assessment under this subsection only in the event that assessments
21 are not preempted by the employee retirement income security act of
22 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the
23 commissioner shall initially request an advisory opinion from the
24 United States department of labor or obtain a declaratory ruling from
25 a federal court on the legality of imposing assessments on these
26 arrangements before imposing the assessment. Once the legality of the
27 assessments has been determined, the multiple employer welfare
28 arrangement certified by the insurance commissioner must begin payment
29 of these assessments.

30 (iii) If there has not been a final determination of the legality
31 of these assessments, then beginning on the earlier of (A) the date the
32 fourth multiple employer welfare arrangement has been certified by the
33 insurance commissioner, or (B) April 1, 2006, the arrangement shall
34 deposit the assessments imposed by this subsection into an interest
35 bearing escrow account maintained by the arrangement. Upon a final
36 determination that the assessments are not preempted by the employee
37 retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001

1 et seq., all funds in the interest bearing escrow account shall be
2 transferred to the board;

3 (f) Issue policies of health coverage in accordance with the
4 requirements of this chapter;

5 (g) Establish procedures for the administration of the premium
6 discount provided under RCW 48.41.200(3)(a)(iii);

7 (h) Contract with the Washington state health care authority for
8 the administration of the premium discounts provided under RCW
9 48.41.200(3)(a) (i) and (ii);

10 (i) Set a reasonable fee to be paid to an insurance agent licensed
11 in Washington state for submitting an acceptable application for
12 enrollment in the pool; and

13 (j) Provide certification to the commissioner when assessments will
14 exceed the threshold level established in RCW 48.41.037.

15 (2) In addition thereto, the board may:

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

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

25 (c) Appoint appropriate legal, actuarial, and other committees as
26 necessary to provide technical assistance in the operation of the pool,
27 policy, and other contract design, and any other function within the
28 authority of the pool; and

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

33 (3) Nothing in this section shall be construed to require or
34 authorize the adoption of rules under chapter 34.05 RCW.

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

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

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

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

12 (c) Any person who resides in a county of the state where no
13 carrier or insurer eligible under chapter 48.15 RCW offers to the
14 public an individual health benefit plan other than a catastrophic
15 health plan as defined in RCW 48.43.005 at the time of application to
16 the pool, and who makes direct application to the pool; and

17 (d) Any medicare eligible person upon providing evidence of
18 rejection for medical reasons, a requirement of restrictive riders, an
19 up-rated premium, or a preexisting conditions limitation on a medicare
20 supplemental insurance policy under chapter 48.66 RCW, the effect of
21 which is to substantially reduce coverage from that received by a
22 person considered a standard risk by at least one member within six
23 months of the date of application.

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

26 (a) Any person having terminated coverage in the pool unless (i)
27 twelve months have lapsed since termination, or (ii) that person can
28 show continuous other coverage which has been involuntarily terminated
29 for any reason other than nonpayment of premiums. However, these
30 exclusions do not apply to eligible individuals as defined in section
31 2741(b) of the federal health insurance portability and accountability
32 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

35 (c) Inmates of public institutions and persons whose benefits are
36 duplicated under public programs. However, these exclusions do not
37 apply to eligible individuals as defined in section 2741(b) of the

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

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

10 (3) When a carrier or insurer regulated under chapter 48.15 RCW
11 begins to offer an individual health benefit plan in a county where no
12 carrier had been offering an individual health benefit plan:

13 (a) If the health benefit plan offered is other than a catastrophic
14 health plan as defined in RCW 48.43.005, any person enrolled in a pool
15 plan pursuant to subsection (1)(c) of this section in that county shall
16 no longer be eligible for coverage under that plan pursuant to
17 subsection (1)(c) of this section, but may continue to be eligible for
18 pool coverage based upon the results of the standard health
19 questionnaire designated by the board and administered by the pool
20 administrator. The pool administrator shall offer to administer the
21 questionnaire to each person no longer eligible for coverage under
22 subsection (1)(c) of this section within thirty days of determining
23 that he or she is no longer eligible;

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

27 (c) The pool administrator shall provide written notice to any
28 person who is no longer eligible for coverage under a pool plan under
29 this subsection (3) within thirty days of the administrator's
30 determination that the person is no longer eligible. The notice shall:
31 (i) Indicate that coverage under the plan will cease ninety days from
32 the date that the notice is dated; (ii) describe any other coverage
33 options, either in or outside of the pool, available to the person;
34 (iii) describe the procedures for the administration of the standard
35 health questionnaire to determine the person's continued eligibility
36 for coverage under subsection (1)(b) of this section; and (iv) describe
37 the enrollment process for the available options outside of the pool.

1 **Sec. 4.** RCW 48.41.110 and 2001 c 196 s 4 are each amended to read
2 as follows:

3 (1) The pool shall offer one or more care management plans of
4 coverage. Such plans may, but are not required to, include point of
5 service features that permit participants to receive in-network
6 benefits or out-of-network benefits subject to differential cost
7 shares. Covered persons enrolled in the pool on January 1, 2001, may
8 continue coverage under the pool plan in which they are enrolled on
9 that date. However, the pool may incorporate managed care features
10 into such existing plans.

11 (2) The administrator shall prepare a brochure outlining the
12 benefits and exclusions of the pool policy in plain language. After
13 approval by the board, such brochure shall be made reasonably available
14 to participants or potential participants.

15 (3) The health insurance policy issued by the pool shall pay only
16 reasonable amounts for medically necessary eligible health care
17 services rendered or furnished for the diagnosis or treatment of
18 illnesses, injuries, and conditions which are not otherwise limited or
19 excluded. Eligible expenses are the reasonable amounts for the health
20 care services and items for which benefits are extended under the pool
21 policy. Such benefits shall at minimum include, but not be limited to,
22 the following services or related items:

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

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

35 (c) The first twenty outpatient professional visits for the
36 diagnosis or treatment of one or more mental or nervous conditions or
37 alcohol, drug, or chemical dependency or abuse rendered during a
38 calendar year by one or more physicians, psychologists, or community

1 mental health professionals, or, at the direction of a physician, by
2 other qualified licensed health care practitioners, in the case of
3 mental or nervous conditions, and rendered by a state certified
4 chemical dependency program approved under chapter 70.96A RCW, in the
5 case of alcohol, drug, or chemical dependency or abuse;

6 (d) Drugs and contraceptive devices requiring a prescription;

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

10 (f) Services of a home health agency;

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

13 (h) Oxygen;

14 (i) Anesthesia services;

15 (j) Prostheses, other than dental;

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

18 (l) Diagnostic x-rays and laboratory tests;

19 (m) Oral surgery limited to the following: Fractures of facial
20 bones; excisions of mandibular joints, lesions of the mouth, lip, or
21 tongue, tumors, or cysts excluding treatment for temporomandibular
22 joints; incision of accessory sinuses, mouth salivary glands or ducts;
23 dislocations of the jaw; plastic reconstruction or repair of traumatic
24 injuries occurring while covered under the pool; and excision of
25 impacted wisdom teeth;

26 (n) Maternity care services;

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

29 (p) Hospice services;

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

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

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

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

10 (6) The pool benefit policy shall be explicitly designed to
11 identify pool enrollees with one or more chronic health conditions, and
12 to provide appropriate, cost-effective care addressing their needs,
13 including the integration of evidence-based chronic care service
14 delivery models into primary care protocols, innovative treatment
15 delivery methods, and support for enrollee self-management.

16 (7) The pool may not reject an individual for health plan coverage
17 based upon preexisting conditions of the individual or deny, exclude,
18 or otherwise limit coverage for an individual's preexisting health
19 conditions; except that it shall impose a six-month benefit waiting
20 period for preexisting conditions for which medical advice was given,
21 for which a health care provider recommended or provided treatment, or
22 for which a prudent layperson would have sought advice or treatment,
23 within six months before the effective date of coverage. The
24 preexisting condition waiting period shall not apply to prenatal care
25 services. The pool may not avoid the requirements of this section
26 through the creation of a new rate classification or the modification
27 of an existing rate classification. Credit against the waiting period
28 shall be as provided in subsection ((7)) (8) of this section.

29 ((7)) (8)(a) Except as provided in (b) of this subsection, the
30 pool shall credit any preexisting condition waiting period in its plans
31 for a person who was enrolled at any time during the sixty-three day
32 period immediately preceding the date of application for the new pool
33 plan. For the person previously enrolled in a group health benefit
34 plan, the pool must credit the aggregate of all periods of preceding
35 coverage not separated by more than sixty-three days toward the waiting
36 period of the new health plan. For the person previously enrolled in
37 an individual health benefit plan other than a catastrophic health
38 plan, the pool must credit the period of coverage the person was

1 continuously covered under the immediately preceding health plan toward
2 the waiting period of the new health plan. For the purposes of this
3 subsection, a preceding health plan includes an employer-provided self-
4 funded health plan.

5 (b) The pool shall waive any preexisting condition waiting period
6 for a person who is an eligible individual as defined in section
7 2741(b) of the federal health insurance portability and accountability
8 act of 1996 (42 U.S.C. 300gg-41(b)).

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

13 **Sec. 5.** RCW 48.41.160 and 1987 c 431 s 16 are each amended to read
14 as follows:

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

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

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

31 (4) During December of each year, any person enrolled in a pool
32 policy, other than the medical supplement policy offered under RCW
33 48.41.150, may move to any other pool policy, other than the medical
34 supplement policy, with an equal or greater deductible. Any person
35 enrolled in a pool policy may move to the medical supplement policy
36 offered under RCW 48.41.150 when he or she enrolls in medicare.

1 **Sec. 6.** RCW 48.41.190 and 1989 c 121 s 10 are each amended to read
2 as follows:

3 (~~Neither the participation by members, the establishment of rates,~~
4 ~~forms, or procedures for coverages issued by the pool, nor any other~~
5 ~~joint or collective action required by this chapter or the state of~~
6 ~~Washington shall be the basis of any legal action, civil or criminal~~
7 ~~liability or penalty against the pool, any member of the board of~~
8 ~~directors, or members of the pool either jointly or separately.)) The
9 pool, members of the pool, board directors of the pool, officers of the
10 pool, employees of the pool, the commissioner, the commissioner's
11 representatives, and the commissioner's employees shall not be civilly
12 or criminally liable and shall not have any penalty or cause of action
13 of any nature arise against them for any action taken or not taken,
14 including any discretionary decision or failure to make a discretionary
15 decision, when the action or inaction is done in good faith and in the
16 performance of the powers and duties under this chapter. However,
17 nothing in this section prohibits legal actions against the pool to
18 enforce the pool's statutory or contractual duties and obligations.~~

19 **Sec. 7.** RCW 48.43.005 and 2004 c 244 s 2 are each amended to read
20 as follows:

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

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

27 (2) "Basic health plan" means the plan described under chapter
28 70.47 RCW, as revised from time to time.

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

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

35 (5) "Catastrophic health plan" means:

36 (a) In the case of a contract, agreement, or policy covering a
37 single enrollee, a health benefit plan requiring a calendar year

1 deductible of, at a minimum, one thousand (~~five~~) seven hundred fifty
2 dollars and an annual out-of-pocket expense required to be paid under
3 the plan (other than for premiums) for covered benefits of at least
4 three thousand five hundred dollars, both amounts to be adjusted
5 annually by the insurance commissioner; and

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

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

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

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

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

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

37 (9) "Dependent" means, at a minimum, the enrollee's legal spouse

1 and unmarried dependent children who qualify for coverage under the
2 enrollee's health benefit plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (b) Medicare supplemental health insurance governed by chapter
32 48.66 RCW;

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

35 (d) Disability income;

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

- 1 (f) Workers' compensation coverage;
2 (g) Accident only coverage;
3 (h) Specified disease and hospital confinement indemnity when
4 marketed solely as a supplement to a health plan;
5 (i) Employer-sponsored self-funded health plans;
6 (j) Dental only and vision only coverage; and
7 (k) Plans deemed by the insurance commissioner to have a short-term
8 limited purpose or duration, or to be a student-only plan that is
9 guaranteed renewable while the covered person is enrolled as a regular
10 full-time undergraduate or graduate student at an accredited higher
11 education institution, after a written request for such classification
12 by the carrier and subsequent written approval by the insurance
13 commissioner.

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

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

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

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

32 (24) "Small employer" or "small group" means any person, firm,
33 corporation, partnership, association, political subdivision, sole
34 proprietor, or self-employed individual that is actively engaged in
35 business that, on at least fifty percent of its working days during the
36 preceding calendar quarter, employed at least two but no more than
37 fifty eligible employees, with a normal work week of thirty or more
38 hours, the majority of whom were employed within this state, and is not

1 formed primarily for purposes of buying health insurance and in which
2 a bona fide employer-employee relationship exists. In determining the
3 number of eligible employees, companies that are affiliated companies,
4 or that are eligible to file a combined tax return for purposes of
5 taxation by this state, shall be considered an employer. Subsequent to
6 the issuance of a health plan to a small employer and for the purpose
7 of determining eligibility, the size of a small employer shall be
8 determined annually. Except as otherwise specifically provided, a
9 small employer shall continue to be considered a small employer until
10 the plan anniversary following the date the small employer no longer
11 meets the requirements of this definition. A self-employed individual
12 or sole proprietor must derive at least seventy-five percent of his or
13 her income from a trade or business through which the individual or
14 sole proprietor has attempted to earn taxable income and for which he
15 or she has filed the appropriate internal revenue service form 1040,
16 schedule C or F, for the previous taxable year except for a self-
17 employed individual or sole proprietor in an agricultural trade or
18 business, who must derive at least fifty-one percent of his or her
19 income from the trade or business through which the individual or sole
20 proprietor has attempted to earn taxable income and for which he or she
21 has filed the appropriate internal revenue service form 1040, for the
22 previous taxable year. A self-employed individual or sole proprietor
23 who is covered as a group of one on the day prior to June 10, 2004,
24 shall also be considered a "small employer" to the extent that
25 individual or group of one is entitled to have his or her coverage
26 renewed as provided in RCW 48.43.035(6).

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

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

1 **Sec. 8.** RCW 48.43.018 and 2004 c 244 s 3 are each amended to read
2 as follows:

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

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

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

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

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

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

26 (c) If a person is seeking an individual health benefit plan due to
27 his or her having exhausted continuation coverage provided under 29
28 U.S.C. Sec. 1161 et seq., completion of the standard health
29 questionnaire shall not be a condition of coverage if application for
30 coverage is made within ninety days of exhaustion of continuation
31 coverage. A health carrier shall accept an application without a
32 standard health questionnaire from a person currently covered by such
33 continuation coverage if application is made within ninety days prior
34 to the date the continuation coverage would be exhausted and the
35 effective date of the individual coverage applied for is the date the
36 continuation coverage would be exhausted, or within ninety days
37 thereafter.

1 (d) If a person is seeking an individual health benefit plan due to
2 his or her receiving notice that his or her coverage under a conversion
3 contract is discontinued, completion of the standard health
4 questionnaire shall not be a condition of coverage if application for
5 coverage is made within ninety days of discontinuation of eligibility
6 under the conversion contract. A health carrier shall accept an
7 application without a standard health questionnaire from a person
8 currently covered by such conversion contract if application is made
9 within ninety days prior to the date eligibility under the conversion
10 contract would be discontinued and the effective date of the individual
11 coverage applied for is the date eligibility under the conversion
12 contract would be discontinued, or within ninety days thereafter.

13 (e) If a person is seeking an individual health benefit plan and,
14 but for the number of persons employed by his or her employer, would
15 have qualified for continuation coverage provided under 29 U.S.C. Sec.
16 1161 et seq., completion of the standard health questionnaire shall not
17 be a condition of coverage if: (i) Application for coverage is made
18 within ninety days of a qualifying event as defined in 29 U.S.C. Sec.
19 1163; and (ii) the person had at least twenty-four months of continuous
20 group coverage immediately prior to the qualifying event. A health
21 carrier shall accept an application without a standard health
22 questionnaire from a person with at least twenty-four months of
23 continuous group coverage if application is made no more than ninety
24 days prior to the date of a qualifying event and the effective date of
25 the individual coverage applied for is the date of the qualifying
26 event, or within ninety days thereafter.

27 (f) If a person is seeking an individual health benefit plan other
28 than a catastrophic health plan, and is enrolled in a catastrophic
29 health plan at the time application for the individual health benefit
30 plan is made, completion of the standard health questionnaire shall not
31 be a condition of coverage if the application for individual coverage
32 is made no more than forty-five and no less than thirty days prior to
33 the date that his or her catastrophic health plan would be annually
34 renewed.

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

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

3 (b) Within fifteen business days of receipt of a completed
4 application, the carrier shall provide written notice of the decision
5 not to accept the person's application for enrollment to both the
6 person and the administrator of the Washington state health insurance
7 pool. The notice to the person shall state that the person is eligible
8 for health insurance provided by the Washington state health insurance
9 pool, and shall include information about the Washington state health
10 insurance pool and an application for such coverage. If the carrier
11 does not provide or postmark such notice within fifteen business days,
12 the application is deemed approved.

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

32 **Sec. 9.** RCW 48.43.041 and 2000 c 79 s 26 are each amended to read
33 as follows:

34 (1) All individual health benefit plans, other than catastrophic
35 health plans, offered or renewed on or after October 1, 2000, shall
36 include benefits described in this section. Nothing in this section

1 shall be construed to require a carrier to offer an individual health
2 benefit plan.

3 (a) Maternity services that include, with no enrollee cost-sharing
4 requirements beyond those generally applicable cost-sharing
5 requirements: Diagnosis of pregnancy; prenatal care; delivery; care
6 for complications of pregnancy; physician services; hospital services;
7 operating or other special procedure rooms; radiology and laboratory
8 services; appropriate medications; anesthesia; and services required
9 under RCW 48.43.115; and

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

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

17 NEW SECTION. **Sec. 10.** This act takes effect January 1, 2007.

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