

CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1870

66th Legislature
2019 Regular Session

Passed by the House April 1, 2019
Yeas 56 Nays 37

Speaker of the House of Representatives

Passed by the Senate March 27, 2019
Yeas 28 Nays 17

President of the Senate

Approved

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1870** as passed by House of Representatives and the Senate on the dates hereon set forth.

Chief Clerk

FILED

**Secretary of State
State of Washington**

1 (2) "Adverse benefit determination" means a denial, reduction, or
2 termination of, or a failure to provide or make payment, in whole or
3 in part, for a benefit, including a denial, reduction, termination,
4 or failure to provide or make payment that is based on a
5 determination of an enrollee's or applicant's eligibility to
6 participate in a plan, and including, with respect to group health
7 plans, a denial, reduction, or termination of, or a failure to
8 provide or make payment, in whole or in part, for a benefit resulting
9 from the application of any utilization review, as well as a failure
10 to cover an item or service for which benefits are otherwise provided
11 because it is determined to be experimental or investigational or not
12 medically necessary or appropriate.

13 (3) "Applicant" means a person who applies for enrollment in an
14 individual health plan as the subscriber or an enrollee, or the
15 dependent or spouse of a subscriber or enrollee.

16 (4) "Basic health plan" means the plan described under chapter
17 70.47 RCW, as revised from time to time.

18 (5) "Basic health plan model plan" means a health plan as
19 required in RCW 70.47.060(2)(e).

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

24 (7) "Board" means the governing board of the Washington health
25 benefit exchange established in chapter 43.71 RCW.

26 (8)(a) For grandfathered health benefit plans issued before
27 January 1, 2014, and renewed thereafter, "catastrophic health plan"
28 means:

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

36 (ii) In the case of a contract, agreement, or policy covering
37 more than one enrollee, a health benefit plan requiring a calendar
38 year deductible of, at a minimum, three thousand five hundred dollars
39 and an annual out-of-pocket expense required to be paid under the
40 plan (other than for premiums) for covered benefits of at least six

1 thousand dollars, both amounts to be adjusted annually by the
2 insurance commissioner.

3 (b) In July 2008, and in each July thereafter, the insurance
4 commissioner shall adjust the minimum deductible and out-of-pocket
5 expense required for a plan to qualify as a catastrophic plan to
6 reflect the percentage change in the consumer price index for medical
7 care for a preceding twelve months, as determined by the United
8 States department of labor. For a plan year beginning in 2014, the
9 out-of-pocket limits must be adjusted as specified in section
10 1302(c)(1) of P.L. 111-148 of 2010, as amended. The adjusted amount
11 shall apply on the following January 1st.

12 (c) For health benefit plans issued on or after January 1, 2014,
13 "catastrophic health plan" means:

14 (i) A health benefit plan that meets the definition of
15 catastrophic plan set forth in section 1302(e) of P.L. 111-148 of
16 2010, as amended; or

17 (ii) A health benefit plan offered outside the exchange
18 marketplace that requires a calendar year deductible or out-of-pocket
19 expenses under the plan, other than for premiums, for covered
20 benefits, that meets or exceeds the commissioner's annual adjustment
21 under (b) of this subsection.

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

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

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

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

37 (13) "Emergency medical condition" means a medical condition
38 manifesting itself by acute symptoms of sufficient severity,
39 including severe pain, such that a prudent layperson, who possesses
40 an average knowledge of health and medicine, could reasonably expect

1 the absence of immediate medical attention to result in a condition
2 (a) placing the health of the individual, or with respect to a
3 pregnant woman, the health of the woman or her unborn child, in
4 serious jeopardy, (b) serious impairment to bodily functions, or (c)
5 serious dysfunction of any bodily organ or part.

6 (14) "Emergency services" means a medical screening examination,
7 as required under section 1867 of the social security act (42 U.S.C.
8 1395dd), that is within the capability of the emergency department of
9 a hospital, including ancillary services routinely available to the
10 emergency department to evaluate that emergency medical condition,
11 and further medical examination and treatment, to the extent they are
12 within the capabilities of the staff and facilities available at the
13 hospital, as are required under section 1867 of the social security
14 act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with
15 respect to an emergency medical condition, has the meaning given in
16 section 1867(e)(3) of the social security act (42 U.S.C.
17 1395dd(e)(3)).

18 (15) "Employee" has the same meaning given to the term, as of
19 January 1, 2008, under section 3(6) of the federal employee
20 retirement income security act of 1974.

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

25 (17) "Exchange" means the Washington health benefit exchange
26 established under chapter 43.71 RCW.

27 (18) "Final external review decision" means a determination by an
28 independent review organization at the conclusion of an external
29 review.

30 (19) "Final internal adverse benefit determination" means an
31 adverse benefit determination that has been upheld by a health plan
32 or carrier at the completion of the internal appeals process, or an
33 adverse benefit determination with respect to which the internal
34 appeals process has been exhausted under the exhaustion rules
35 described in RCW 48.43.530 and 48.43.535.

36 (20) "Grandfathered health plan" means a group health plan or an
37 individual health plan that under section 1251 of the patient
38 protection and affordable care act, P.L. 111-148 (2010) and as
39 amended by the health care and education reconciliation act, P.L.

1 111-152 (2010) is not subject to subtitles A or C of the act as
2 amended.

3 (21) "Grievance" means a written complaint submitted by or on
4 behalf of a covered person regarding service delivery issues other
5 than denial of payment for medical services or nonprovision of
6 medical services, including dissatisfaction with medical care,
7 waiting time for medical services, provider or staff attitude or
8 demeanor, or dissatisfaction with service provided by the health
9 carrier.

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

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

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

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

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

32 (25) "Health carrier" or "carrier" means a disability insurer
33 regulated under chapter 48.20 or 48.21 RCW, a health care service
34 contractor as defined in RCW 48.44.010, or a health maintenance
35 organization as defined in RCW 48.46.020, and includes "issuers" as
36 that term is used in the patient protection and affordable care act
37 (P.L. 111-148).

38 (26) "Health plan" or "health benefit plan" means any policy,
39 contract, or agreement offered by a health carrier to provide,

1 arrange, reimburse, or pay for health care services except the
2 following:

3 (a) Long-term care insurance governed by chapter 48.84 or 48.83
4 RCW;

5 (b) Medicare supplemental health insurance governed by chapter
6 48.66 RCW;

7 (c) Coverage supplemental to the coverage provided under chapter
8 55, Title 10, United States Code;

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

11 (e) Disability income;

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

15 (g) Workers' compensation coverage;

16 (h) Accident only coverage;

17 (i) Specified disease or illness-triggered fixed payment
18 insurance, hospital confinement fixed payment insurance, or other
19 fixed payment insurance offered as an independent, noncoordinated
20 benefit;

21 (j) Employer-sponsored self-funded health plans;

22 (k) Dental only and vision only coverage;

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

30 (m) Civilian health and medical program for the veterans affairs
31 administration (CHAMPVA).

32 (27) "Individual market" means the market for health insurance
33 coverage offered to individuals other than in connection with a group
34 health plan.

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

38 (29) "Open enrollment" means a period of time as defined in rule
39 to be held at the same time each year, during which applicants may
40 enroll in a carrier's individual health benefit plan without being

1 subject to health screening or otherwise required to provide evidence
2 of insurability as a condition for enrollment.

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

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

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

19 (33) "Small employer" or "small group" means any person, firm,
20 corporation, partnership, association, political subdivision, sole
21 proprietor, or self-employed individual that is actively engaged in
22 business that employed an average of at least one but no more than
23 fifty employees, during the previous calendar year and employed at
24 least one employee on the first day of the plan year, is not formed
25 primarily for purposes of buying health insurance, and in which a
26 bona fide employer-employee relationship exists. In determining the
27 number of employees, companies that are affiliated companies, or that
28 are eligible to file a combined tax return for purposes of taxation
29 by this state, shall be considered an employer. Subsequent to the
30 issuance of a health plan to a small employer and for the purpose of
31 determining eligibility, the size of a small employer shall be
32 determined annually. Except as otherwise specifically provided, a
33 small employer shall continue to be considered a small employer until
34 the plan anniversary following the date the small employer no longer
35 meets the requirements of this definition. A self-employed individual
36 or sole proprietor who is covered as a group of one must also: (a)
37 Have been employed by the same small employer or small group for at
38 least twelve months prior to application for small group coverage,
39 and (b) verify that he or she derived at least seventy-five percent
40 of his or her income from a trade or business through which the

1 individual or sole proprietor has attempted to earn taxable income
2 and for which he or she has filed the appropriate internal revenue
3 service form 1040, schedule C or F, for the previous taxable year,
4 except a self-employed individual or sole proprietor in an
5 agricultural trade or business, must have derived at least fifty-one
6 percent of his or her income from the trade or business through which
7 the individual or sole proprietor has attempted to earn taxable
8 income and for which he or she has filed the appropriate internal
9 revenue service form 1040, for the previous taxable year.

10 (34) "Special enrollment" means a defined period of time of not
11 less than thirty-one days, triggered by a specific qualifying event
12 experienced by the applicant, during which applicants may enroll in
13 the carrier's individual health benefit plan without being subject to
14 health screening or otherwise required to provide evidence of
15 insurability as a condition for enrollment.

16 (35) "Standard health questionnaire" means the standard health
17 questionnaire designated under chapter 48.41 RCW.

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

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

30 (38) "Essential health benefit categories" means:

31 (a) Ambulatory patient services;

32 (b) Emergency services;

33 (c) Hospitalization;

34 (d) Maternity and newborn care;

35 (e) Mental health and substance use disorder services, including
36 behavioral health treatment;

37 (f) Prescription drugs;

38 (g) Rehabilitative and habilitative services and devices;

39 (h) Laboratory services;

- 1 (i) Preventive and wellness services and chronic disease
2 management; and
3 (j) Pediatric services, including oral and vision care.

4 **PART II**
5 **GUARANTEED ISSUE AND ELIGIBILITY**

6 **Sec. 2.** RCW 48.43.012 and 2011 c 315 s 3 are each amended to
7 read as follows:

8 (1) No carrier may reject an individual for an individual or
9 group health benefit plan based upon preexisting conditions of the
10 individual (~~(except as provided in RCW 48.43.018)~~).

11 (2) No carrier may deny, exclude, or otherwise limit coverage for
12 an individual's preexisting health conditions (~~(except as provided in~~
13 ~~this section)~~) including, but not limited to, preexisting condition
14 exclusions or waiting periods.

15 (~~(For an individual health benefit plan originally issued on~~
16 ~~or after March 23, 2000, preexisting condition waiting periods~~
17 ~~imposed upon a person enrolling in an individual health benefit plan~~
18 ~~shall be no more than nine months for a preexisting condition for~~
19 ~~which medical advice was given, for which a health care provider~~
20 ~~recommended or provided treatment, or for which a prudent layperson~~
21 ~~would have sought advice or treatment, within six months prior to the~~
22 ~~effective date of the plan. No carrier may impose a preexisting~~
23 ~~condition waiting period on an individual health benefit plan issued~~
24 ~~to an eligible individual as defined in section 2741(b) of the~~
25 ~~federal health insurance portability and accountability act of 1996~~
26 ~~(42 U.S.C. 300gg-41(b)).~~

27 (~~(4) Individual health benefit plan preexisting condition waiting~~
28 ~~periods shall not apply to prenatal care services.~~

29 (~~(5)~~) No carrier may avoid the requirements of this section
30 through the creation of a new rate classification or the modification
31 of an existing rate classification. A new or changed rate
32 classification will be deemed an attempt to avoid the provisions of
33 this section if the new or changed classification would substantially
34 discourage applications for coverage from individuals who are higher
35 than average health risks. These provisions apply only to individuals
36 who are Washington residents.

37 (~~(6) For any person under age nineteen applying for coverage as~~
38 ~~allowed by RCW 48.43.0122(1) or enrolled in a health benefit plan~~

1 ~~subject to sections 1201 and 10103 of the patient protection and~~
2 ~~affordable care act (P.L. 111-148) that is not a grandfathered health~~
3 ~~plan in the individual market, a carrier must not impose a~~
4 ~~preexisting condition exclusion or waiting period or other~~
5 ~~limitations on benefits or enrollment due to a preexisting~~
6 ~~condition.))~~

7 (4) Unless preempted by federal law, the commissioner shall adopt
8 any rules necessary to implement this section, consistent with
9 federal rules and guidance in effect on January 1, 2017, implementing
10 the patient protection and affordable care act.

11 NEW SECTION. Sec. 3. A new section is added to chapter 48.43
12 RCW to read as follows:

13 (1) A health carrier or health plan may not establish rules for
14 eligibility, including continued eligibility, of any individual to
15 enroll under the terms of the plan or coverage based on any of the
16 following health status-related factors in relation to the individual
17 or a dependent of the individual:

- 18 (a) Health status;
- 19 (b) Medical condition, including both physical and mental
20 illnesses;
- 21 (c) Claims experience;
- 22 (d) Receipt of health care;
- 23 (e) Medical history;
- 24 (f) Genetic information;
- 25 (g) Evidence of insurability, including conditions arising out of
26 acts of domestic violence;
- 27 (h) Disability; or
- 28 (i) Any other health status-related factor determined appropriate
29 by the commissioner.

30 (2) Unless preempted by federal law, the commissioner shall adopt
31 any rules necessary to implement this section, consistent with
32 federal rules and guidance in effect on January 1, 2017, implementing
33 the patient protection and affordable care act.

34 **Sec. 4.** RCW 48.21.270 and 2011 c 314 s 2 are each amended to
35 read as follows:

36 (1) An insurer shall not require proof of insurability as a
37 condition for issuance of the conversion policy.

1 (2) A conversion policy may not contain an exclusion for
2 preexisting conditions for any applicant (~~who is under age nineteen.~~
3 ~~For policies issued to those age nineteen and older, an exclusion for~~
4 ~~a preexisting condition is permitted only to the extent that a~~
5 ~~waiting period for a preexisting condition has not been satisfied~~
6 ~~under the group policy~~)).

7 (3) An insurer must offer at least three policy benefit plans
8 that comply with the following:

9 (a) A major medical plan with a five thousand dollar deductible
10 per person;

11 (b) A comprehensive medical plan with a five hundred dollar
12 deductible per person; and

13 (c) A basic medical plan with a one thousand dollar deductible
14 per person.

15 (4) The insurance commissioner may revise the deductible amounts
16 in subsection (3) of this section from time to time to reflect
17 changing health care costs.

18 (5) The insurance commissioner shall adopt rules to establish
19 minimum benefit standards for conversion policies.

20 (6) The commissioner shall adopt rules to establish specific
21 standards for conversion policy provisions. These rules may include
22 but are not limited to:

23 (a) Terms of renewability;

24 (b) Nonduplication of coverage;

25 (c) Benefit limitations, exceptions, and reductions; and

26 (d) Definitions of terms.

27 **Sec. 5.** RCW 48.44.380 and 2011 c 314 s 7 are each amended to
28 read as follows:

29 (1) A health care service contractor shall not require proof of
30 insurability as a condition for issuance of the conversion contract.

31 (2) A conversion contract may not contain an exclusion for
32 preexisting conditions for any applicant (~~who is under age nineteen.~~
33 ~~For policies issued to those age nineteen and older, an exclusion for~~
34 ~~a preexisting condition is permitted only to the extent that a~~
35 ~~waiting period for a preexisting condition has not been satisfied~~
36 ~~under the group contract~~)).

37 (3) A health care service contractor must offer at least three
38 contract benefit plans that comply with the following:

1 (a) A major medical plan with a five thousand dollar deductible
2 per person;

3 (b) A comprehensive medical plan with a five hundred dollar
4 deductible per person; and

5 (c) A basic medical plan with a one thousand dollar deductible
6 per person.

7 (4) The insurance commissioner may revise the deductible amounts
8 in subsection (3) of this section from time to time to reflect
9 changing health care costs.

10 (5) The insurance commissioner shall adopt rules to establish
11 minimum benefit standards for conversion contracts.

12 (6) The commissioner shall adopt rules to establish specific
13 standards for conversion contract provisions. These rules may include
14 but are not limited to:

15 (a) Terms of renewability;

16 (b) Nonduplication of coverage;

17 (c) Benefit limitations, exceptions, and reductions; and

18 (d) Definitions of terms.

19 **Sec. 6.** RCW 48.46.460 and 2011 c 314 s 9 are each amended to
20 read as follows:

21 (1) A health maintenance organization must offer a conversion
22 agreement for comprehensive health care services and shall not
23 require proof of insurability as a condition for issuance of the
24 conversion agreement.

25 (2) A conversion agreement may not contain an exclusion for
26 preexisting conditions for an applicant (~~who is under age nineteen.~~
27 ~~For policies issued to those age nineteen and older, an exclusion for~~
28 ~~a preexisting condition is permitted only to the extent that a~~
29 ~~waiting period for a preexisting condition has not been satisfied~~
30 ~~under the group agreement)).~~

31 (3) A conversion agreement need not provide benefits identical to
32 those provided under the group agreement. The conversion agreement
33 may contain provisions requiring the person covered by the conversion
34 agreement to pay reasonable deductibles and copayments, except for
35 preventive service benefits as defined in 45 C.F.R. 147.130 (2010),
36 implementing sections 2701 through 2763, 2791, and 2792 of the public
37 health service act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and
38 300gg-92), as amended.

1 (4) The insurance commissioner shall adopt rules to establish
2 minimum benefit standards for conversion agreements.

3 (5) The commissioner shall adopt rules to establish specific
4 standards for conversion agreement provisions. These rules may
5 include but are not limited to:

- 6 (a) Terms of renewability;
- 7 (b) Nonduplication of coverage;
- 8 (c) Benefit limitations, exceptions, and reductions; and
- 9 (d) Definitions of terms.

10 NEW SECTION. **Sec. 7.** The following acts or parts of acts are
11 each repealed:

12 (1) RCW 48.43.015 (Health benefit plans—Preexisting conditions)
13 and 2012 c 64 s 2, 2004 c 192 s 5, 2001 c 196 s 7, 2000 c 80 s 3,
14 2000 c 79 s 20, & 1995 c 265 s 5;

15 (2) RCW 48.43.017 (Organ transplant benefit waiting periods—Prior
16 creditable coverage) and 2009 c 82 s 2;

17 (3) RCW 48.43.018 (Requirement to complete the standard health
18 questionnaire—Exemptions—Results) and 2012 c 211 s 16, 2012 c 64 s
19 1, 2010 c 277 s 1, & 2009 c 42 s 1; and

20 (4) RCW 48.43.025 (Group health benefit plans—Preexisting
21 conditions) and 2001 c 196 s 9, 2000 c 79 s 23, & 1995 c 265 s 6.

22 **PART III**

23 **PROHIBITING UNFAIR RESCISSIONS**

24 NEW SECTION. **Sec. 8.** A new section is added to chapter 48.43
25 RCW to read as follows:

26 (1) A health plan or health carrier offering group or individual
27 coverage may not rescind such coverage with respect to an enrollee
28 once the enrollee is covered under the plan or coverage involved,
29 except that this section does not apply to a covered person who has
30 performed an act or practice that constitutes fraud or makes an
31 intentional misrepresentation of material fact as prohibited by the
32 terms of the plan or coverage. The plan or coverage may not be
33 canceled except as permitted under RCW 48.43.035 or 48.43.038.

34 (2) The commissioner shall adopt any rules necessary to implement
35 this section, consistent with federal rules and guidance in effect on

1 January 1, 2017, implementing the patient protection and affordable
2 care act.

3 **PART IV**
4 **ESSENTIAL HEALTH BENEFITS**

5 **Sec. 9.** RCW 48.43.715 and 2013 c 325 s 1 are each amended to
6 read as follows:

7 (1) ~~((Consistent with federal law,))~~ The commissioner, in
8 consultation with the board and the health care authority, shall, by
9 rule, select the largest small group plan in the state by enrollment
10 as the benchmark plan for the individual and small group market for
11 purposes of establishing the essential health benefits in Washington
12 state ~~((under P.L. 111-148 of 2010, as amended))~~.

13 (2) If the essential health benefits benchmark plan for the
14 individual and small group market does not include all of the ten
15 essential health benefits categories ~~((specified by section 1302 of~~
16 ~~P.L. 111-148, as amended))~~, the commissioner, in consultation with
17 the board and the health care authority, shall, by rule, supplement
18 the benchmark plan benefits as needed ~~((to meet the minimum~~
19 ~~requirements of section 1302))~~.

20 (3) ((A)) All individual and small group health plans ~~((required~~
21 ~~to offer))~~ must cover the ten essential health benefits categories,
22 other than a health plan offered through the federal basic health
23 program, a grandfathered health plan, or medicaid~~((, under P.L.~~
24 ~~111-148 of 2010, as amended,))~~. Such a health plan may not be offered
25 in the state unless the commissioner finds that it is substantially
26 equal to the benchmark plan. When making this determination, the
27 commissioner:

28 (a) Must ensure that the plan covers the ten essential health
29 benefits categories ~~((specified in section 1302 of P.L. 111-148 of~~
30 ~~2010, as amended))~~;

31 (b) May consider whether the health plan has a benefit design
32 that would create a risk of biased selection based on health status
33 and whether the health plan contains meaningful scope and level of
34 benefits in each of the ten essential health benefits categories
35 ~~((specified by section 1302 of P.L. 111-148 of 2010, as amended))~~;

36 (c) Notwithstanding ~~((the foregoing))~~ (a) and (b) of this
37 subsection, for benefit years beginning January 1, 2015, ~~((and only~~
38 ~~to the extent permitted by federal law and guidance,))~~ must establish

1 by rule the review and approval requirements and procedures for
2 pediatric oral services when offered in stand-alone dental plans in
3 the nongrandfathered individual and small group markets outside of
4 the exchange; and

5 (d) (~~Unless prohibited by federal law and guidance,~~) Must allow
6 health carriers to also offer pediatric oral services within the
7 health benefit plan in the nongrandfathered individual and small
8 group markets outside of the exchange.

9 (4) Beginning December 15, 2012, and every year thereafter, the
10 commissioner shall submit to the legislature a list of state-mandated
11 health benefits, the enforcement of which will result in federally
12 imposed costs to the state related to the plans sold through the
13 exchange because the benefits are not included in the essential
14 health benefits designated under federal law. The list must include
15 the anticipated costs to the state of each state-mandated health
16 benefit on the list and any statutory changes needed if funds are not
17 appropriated to defray the state costs for the listed mandate. The
18 commissioner may enforce a mandate on the list for the entire market
19 only if funds are appropriated in an omnibus appropriations act
20 specifically to pay the state portion of the identified costs.

21 **PART V**

22 **COST SHARING**

23 NEW SECTION. **Sec. 10.** A new section is added to chapter 48.43
24 RCW to read as follows:

25 (1) For plan years beginning in 2020, the cost sharing incurred
26 under a health plan for the essential health benefits may not exceed
27 the following amounts:

28 (a) For self-only coverage:

29 (i) The amount required under federal law for the calendar year;
30 or

31 (ii) If there are no cost-sharing requirements under federal law,
32 eight thousand two hundred dollars increased by the premium
33 adjustment percentage for the calendar year.

34 (b) For coverage other than self-only coverage:

35 (i) The amount required under federal law for the calendar year;
36 or

1 (ii) If there are no cost-sharing requirements under federal law,
2 sixteen thousand four hundred dollars increased by the premium
3 adjustment percentage for the calendar year.

4 (2) Regardless of whether an enrollee is covered by a self-only
5 plan or a plan that is other than self-only, the enrollee's cost
6 sharing for the essential health benefits may not exceed the self-
7 only annual limitation on cost sharing.

8 (3) For purposes of this section, "the premium adjustment
9 percentage for the calendar year" means the percentage, if any, by
10 which the average per capita premium for health insurance in
11 Washington for the preceding year, as estimated by the commissioner
12 no later than April 1st of such preceding year, exceeds such average
13 per capita premium for 2020 as determined by the commissioner.

14 (4) Unless preempted by federal law, the commissioner shall adopt
15 any rules necessary to implement this section, consistent with
16 federal rules and guidance in effect on January 1, 2017, implementing
17 the patient protection and affordable care act.

18 **PART VI**

19 **OPEN ENROLLMENT PERIODS**

20 **Sec. 11.** RCW 48.43.0122 and 2011 c 315 s 4 are each amended to
21 read as follows:

22 (1) The commissioner shall adopt rules establishing and
23 implementing requirements for the open enrollment periods and special
24 enrollment periods that carriers must follow for individual health
25 benefit plans (~~(and enrollment of persons under age nineteen)~~).

26 (2) The commissioner shall monitor the sale of individual health
27 benefit plans and if a carrier refuses to sell guaranteed issue
28 policies to persons (~~(under age nineteen)~~) in compliance with rules
29 adopted by the commissioner pursuant to subsection (1) of this
30 section, the commissioner may levy fines or suspend or revoke a
31 certificate of authority as provided in chapter 48.05 RCW.

32 **PART VII**

33 **LIFETIME LIMITS**

34 NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43
35 RCW to read as follows:

1 A health carrier may not impose annual or lifetime dollar limits
2 on an essential health benefit, other than those permitted as
3 reference-based limitations under rules adopted by the commissioner.

4 **PART VIII**

5 **EXPLANATION OF COVERAGE**

6 NEW SECTION. **Sec. 13.** A new section is added to chapter 48.43
7 RCW to read as follows:

8 (1) The commissioner shall develop standards for use by a health
9 carrier offering individual or group coverage, in compiling and
10 providing to applicants and enrollees a summary of benefits and
11 coverage explanation that accurately describes the benefits and
12 coverage under the applicable plan. In developing the standards, the
13 commissioner must use the standards developed under 42 U.S.C. Sec.
14 300gg-15 in use on the effective date of this section.

15 (2) The standards must provide for the following:

16 (a) The standards must ensure that the summary of benefits and
17 coverage is presented in a uniform format that does not exceed four
18 pages in length and does not include print smaller than twelve-point
19 font.

20 (b) The standards must ensure that the summary is presented in a
21 culturally and linguistically appropriate manner and utilizes
22 terminology understandable by the average plan enrollee.

23 (c) The standards must ensure that the summary of benefits and
24 coverage includes:

25 (i) Uniform definitions of standard insurance and medical terms,
26 consistent with the standard definitions developed under this
27 section, so that consumers may compare health insurance coverage and
28 understand the terms of coverage, or exceptions to such coverage;

29 (ii) A description of the coverage, including cost sharing for:

30 (A) The essential health benefits; and

31 (B) Other benefits identified by the commissioner;

32 (iii) The exceptions, reductions, and limitations on coverage;

33 (iv) The cost-sharing provisions, including deductible,
34 coinsurance, and copayment obligations;

35 (v) The renewability and continuation of coverage provisions;

36 (vi) A coverage facts label that includes examples to illustrate
37 common benefits scenarios, including pregnancy and serious or chronic

1 medical conditions and related cost sharing. The scenarios must be
2 based on recognized clinical practice guidelines;

3 (vii) A statement of whether the plan:

4 (A) Provides minimum essential coverage under 26 U.S.C. Sec.
5 5000A(f); and

6 (B) Ensures that the plan share of the total allowed costs of
7 benefits provided under the plan is no less than sixty percent of the
8 costs;

9 (viii) A statement that the outline is a summary of the policy or
10 certificate and that the coverage document itself should be consulted
11 to determine the governing contractual provisions; and

12 (ix) A contact number for the consumer to call with additional
13 questions and a web site where a copy of the actual individual
14 coverage policy or group certificate of coverage may be reviewed and
15 obtained.

16 (3) The commissioner shall periodically review and update the
17 standards developed under this section.

18 (4) A health carrier must provide a summary of benefits and
19 coverage explanation to:

20 (a) An applicant at the time of application;

21 (b) An enrollee prior to the time of enrollment or reenrollment,
22 as applicable; and

23 (c) A policyholder or certificate holder at the time of issuance
24 of the policy or delivery of the certificate.

25 (5) A health carrier may provide the summary of benefits and
26 coverage either in paper or electronically.

27 (6) If a health carrier makes any material modification in any of
28 the terms of the plan that is not reflected in the most recently
29 provided summary of benefits and coverage, the carrier shall provide
30 notice of the modification to enrollees no later than sixty days
31 prior to the date on which the modification will become effective.

32 (7) A health carrier that fails to provide the information
33 required under this section is subject to a fine of no more than one
34 thousand dollars for each failure. A failure with respect to each
35 enrollee constitutes a separate offense for purposes of this
36 subsection.

37 (8) The commissioner shall, by rule, provide for the development
38 of standards for the definitions of terms used in health insurance
39 coverage, including the following:

1 (a) Insurance-related terms, including premium; deductible;
2 coinsurance; copayment; out-of-pocket limit; preferred provider;
3 nonpreferred provider; out-of-network copayments; usual, customary,
4 and reasonable fees; excluded services; grievance; appeals; and any
5 other terms the commissioner determines are important to define so
6 that consumers may compare health insurance coverage and understand
7 the terms of their coverage; and

8 (b) Medical terms, including hospitalization, hospital outpatient
9 care, emergency room care, physician services, prescription drug
10 coverage, durable medical equipment, home health care, skilled
11 nursing care, rehabilitation services, hospice services, emergency
12 medical transportation, and any other terms the commissioner
13 determines are important to define so that consumers may compare the
14 medical benefits offered by health insurance and understand the
15 extent of those medical benefits or exceptions to those benefits.

16 (9) Unless preempted by federal law, the commissioner shall adopt
17 any rules necessary to implement this section, consistent with
18 federal rules and guidance in effect on January 1, 2017, implementing
19 the patient protection and affordable care act.

20 **PART IX**

21 **WAITING PERIODS FOR GROUP COVERAGE**

22 NEW SECTION. **Sec. 14.** A new section is added to chapter 48.43
23 RCW to read as follows:

24 (1) A group health plan and a health carrier offering group
25 health coverage may not apply any waiting period that exceeds ninety
26 days.

27 (2) Unless preempted by federal law, the commissioner shall adopt
28 any rules necessary to implement this section, consistent with
29 federal rules and guidance in effect on January 1, 2017, implementing
30 the patient protection and affordable care act.

31 **PART X**

32 **PROHIBITING ISSUER AND HEALTH PLAN DISCRIMINATION**

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

35 (1) A health carrier offering a nongrandfathered health plan in
36 the individual or small group market may not:

1 (a) In its benefit design or implementation of its benefit
2 design, discriminate against individuals because of their age,
3 expected length of life, present or predicted disability, degree of
4 medical dependency, quality of life, or other health conditions; and

5 (b) With respect to the health plan, discriminate on the basis of
6 race, color, national origin, disability, age, sex, gender identity,
7 or sexual orientation.

8 (2) Nothing in this section may be construed to prevent an issuer
9 from appropriately utilizing reasonable medical management
10 techniques.

11 (3) Unless preempted by federal law, the commissioner shall adopt
12 any rules necessary to implement this section, consistent with
13 federal rules and guidance in effect on January 1, 2017, implementing
14 the patient protection and affordable care act.

15 NEW SECTION. **Sec. 16.** A new section is added to chapter 43.71
16 RCW to read as follows:

17 (1) For qualified health plans, an issuer offering a qualified
18 health plan may not employ marketing practices or benefit designs
19 that have the effect of discouraging enrollment in the plan by
20 individuals with significant health needs.

21 (2) Unless preempted by federal law, the commissioner shall adopt
22 any rules necessary to implement this section, consistent with
23 federal rules and guidance in effect on January 1, 2017, implementing
24 the patient protection and affordable care act.

25 NEW SECTION. **Sec. 17.** This act is necessary for the immediate
26 preservation of the public peace, health, or safety, or support of
27 the state government and its existing public institutions, and takes
28 effect immediately.

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