S-0533.2

SENATE BILL 5371

State of Washington 62nd Legislature 2011 Regular Session

By Senators Keiser and Conway

Read first time 01/21/11. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to guaranteed issue health insurance for persons
2 under age nineteen; amending RCW 48.43.012 and 48.41.100; reenacting
3 and amending RCW 48.43.005 and 48.41.110; adding a new section to
4 chapter 48.43 RCW; and creating a new section.

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

6 NEW SECTION. **Sec. 1.** The federal patient protection and
7 affordable care act (P.L. 111-148) prohibits insurance carriers from
8 applying preexisting condition limitations for persons under age
9 nineteen, beginning on or after September 23, 2010. The guidance from
10 the United States department of health and human services provides some
11 guidance for the implementation of the new policy requirement, and the
12 office of insurance commissioner further clarified open enrollment
13 requirements to help prevent disruption in the individual health
14 insurance marketplace. It is the intent of this act to:
15 (1) Maintain access to individual plan options for persons under
16 age nineteen;
17 (2) Provide clarity for the establishment of open enrollment and
18 special open enrollment periods that balance access to guaranteed issue
19 coverage with efforts that protect market stability; and

(3) Prohibit a carrier from selling new individual policies if the carrier does not sell policies to persons under age nineteen, under specified requirements. A carrier offering coverage in the individual market that fails to write new policies for persons under age nineteen will be prohibited from offering new individual plan contracts or policies in this state for five years or until the commissioner certifies the exchange established in the patient protection and affordable care act is available for market participation.

Sec. 2. RCW 48.43.005 and 2010 c 292 s 1 are each reenacted and 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) "Applicant" means a person who applies for enrollment in an individual health plan as the subscriber or an enrollee, or the dependent or spouse of a subscriber or enrollee.

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

((~~(3)~~)) (4) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(e).

((~~(4)~~)) (5) "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)~~)) (6) "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 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 six thousand 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.

In July 2008, and in each July 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 a preceding twelve months, as determined by the United States department of labor. The adjusted amount shall apply on the following January 1st.

((~~(6)~~)) (7) "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)~~)) (8) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

((~~(8)~~)) (9) "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)~~)) (10) "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)~~)) (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.

((~~(11)~~)) (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.

((~~(12)~~)) (13) "Employee" has the same meaning given to the term, as of January 1, 2008, under section 3(6) of the federal employee retirement income security act of 1974.

((~~(13)~~)) (14) "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)~~)) (15) "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)~~)) (16) "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)~~)) (17) "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)~~)) (18) "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)~~)) (19) "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, and includes "issuers" as that term is used in the patient protection and affordable care act (P.L. 111-148).

((~~(19)~~)) (20) "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 or 48.83 RCW;

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

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

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

(e) Disability income;

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

(g) Workers' compensation coverage;

(h) Accident only coverage;

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

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

(k) Dental only and vision only coverage; and

(l) 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

1 education institution, after a written request for such classification
2 by the carrier and subsequent written approval by the insurance
3 commissioner.

4 ((~~(20)~~)) <u>(21)</u> "Material modification" means a change in the
5 actuarial value of the health plan as modified of more than five
6 percent but less than fifteen percent.

7 ((~~(21)~~)) <u>(22) "Open enrollment" means a period of time as defined</u>
8 <u>in rule to be held at the same time each year, during which applicants</u>
9 <u>may enroll in a carrier's individual health benefit plan without being</u>
10 <u>subject to health screening or otherwise required to provide evidence</u>
11 <u>of insurability as a condition for enrollment.</u>

12 <u>(23)</u> "Preexisting condition" means any medical condition, illness,
13 or injury that existed any time prior to the effective date of
14 coverage.

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

22 ((~~(23)~~)) <u>(25)</u> "Review organization" means a disability insurer
23 regulated under chapter 48.20 or 48.21 RCW, health care service
24 contractor as defined in RCW 48.44.010, or health maintenance
25 organization as defined in RCW 48.46.020, and entities affiliated with,
26 under contract with, or acting on behalf of a health carrier to perform
27 a utilization review.

28 ((~~(24)~~)) <u>(26)</u> "Small employer" or "small group" means any person,
29 firm, corporation, partnership, association, political subdivision,
30 sole proprietor, or self-employed individual that is actively engaged
31 in business that employed an average of at least one but no more than
32 fifty employees, during the previous calendar year and employed at
33 least one employee on the first day of the plan year, is not formed
34 primarily for purposes of buying health insurance, and in which a bona
35 fide employer-employee relationship exists. In determining the number
36 of employees, companies that are affiliated companies, or that are
37 eligible to file a combined tax return for purposes of taxation by this
38 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 who is covered as a group of one must also: (a) Have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived 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 a self-employed individual or sole proprietor in an agricultural trade or business, must have derived 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.

((~~(25)~~)) (27) "Special enrollment" means a defined period of time of not less than thirty-one days, triggered by a specific qualifying event experienced by the applicant, during which applicants may enroll in the carrier's individual health benefit plan without being subject to health screening or otherwise required to provide evidence of insurability as a condition for enrollment.

(28) "Standard health questionnaire" means the standard health questionnaire designated under chapter 48.41 RCW.

(29) "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)~~)) (30) "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

1 for the purpose of improving enrollee health status and reducing health
2 service costs.

3 **Sec. 3.** RCW 48.43.012 and 2001 c 196 s 6 are each amended to read
4 as follows:
5 (1) No carrier may reject an individual for an individual health
6 benefit plan based upon preexisting conditions of the individual except
7 as provided in RCW 48.43.018.
8 (2) No carrier may deny, exclude, or otherwise limit coverage for
9 an individual's preexisting health conditions except as provided in
10 this section.
11 (3) For an individual health benefit plan originally issued on or
12 after March 23, 2000, preexisting condition waiting periods imposed
13 upon a person enrolling in an individual health benefit plan shall be
14 no more than nine months for a preexisting condition for which medical
15 advice was given, for which a health care provider recommended or
16 provided treatment, or for which a prudent layperson would have sought
17 advice or treatment, within six months prior to the effective date of
18 the plan. No carrier may impose a preexisting condition waiting period
19 on an individual health benefit plan issued to an eligible individual
20 as defined in section 2741(b) of the federal health insurance
21 portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).
22 (4) Individual health benefit plan preexisting condition waiting
23 periods shall not apply to prenatal care services.
24 (5) No carrier may avoid the requirements of this section through
25 the creation of a new rate classification or the modification of an
26 existing rate classification. A new or changed rate classification
27 will be deemed an attempt to avoid the provisions of this section if
28 the new or changed classification would substantially discourage
29 applications for coverage from individuals who are higher than average
30 health risks. These provisions apply only to individuals who are
31 Washington residents.
32 <u>(6) A carrier must waive any exclusion of benefits, including a</u>
33 <u>denial of coverage, and may not otherwise limit coverage based upon a</u>
34 <u>preexisting condition waiting period if the applicant or enrollee is a</u>
35 <u>person under age nineteen. This requirement: (a) Does not apply to an</u>
36 <u>individual grandfathered plan under the patient protection and</u>
37 <u>affordable care act (P.L. 111-148); and (b) includes those persons</u>

1 under age nineteen with a preexisting condition who seek coverage as
2 the primary insured or as a dependent or as a spouse under individual
3 health benefit plans that permit the enrollment of dependents, and
4 enrolled persons under age nineteen who seek benefits for which they
5 are otherwise eligible.

6 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW
7 to read as follows:
8 (1) The commissioner shall adopt rules establishing and
9 implementing requirements for the open enrollment periods and special
10 enrollment periods that carriers must follow for individual health
11 benefit plans and enrollment of persons under age nineteen.
12 (2) The commissioner shall monitor the sale of individual health
13 benefit plans and if a carrier refuses to sell guaranteed issue
14 policies to persons under age nineteen, the commissioner must prohibit
15 the carrier from selling any individual policies in the state for five
16 years or until such time the commissioner certifies the exchange as
17 established under the federal patient protection and affordable care
18 act (P.L. 111-148) is available for market participation.

19 **Sec. 5.** RCW 48.41.100 and 2009 c 555 s 3 are each amended to read
20 as follows:
21 (1)(a) The following persons who are residents of this state are
22 eligible for pool coverage:
23 (i) Any person who provides evidence of a carrier's decision not to
24 accept him or her for enrollment in an individual health benefit plan
25 as defined in RCW 48.43.005 based upon, and within ninety days of the
26 receipt of, the results of the standard health questionnaire designated
27 by the board and administered by health carriers under RCW 48.43.018;
28 (ii) Any person who continues to be eligible for pool coverage
29 based upon the results of the standard health questionnaire designated
30 by the board and administered by the pool administrator pursuant to
31 subsection (3) of this section;
32 (iii) Any person who resides in a county of the state where no
33 carrier or insurer eligible under chapter 48.15 RCW offers to the
34 public an individual health benefit plan other than a catastrophic
35 health plan as defined in RCW 48.43.005 at the time of application to
36 the pool, and who makes direct application to the pool;

(iv) Any person becoming eligible for medicare before August 1, 2009, who provides evidence of (A) a rejection for medical reasons, (B) a requirement of restrictive riders, (C) an up-rated premium, (D) a preexisting conditions limitation, or (E) lack of access to or for a comprehensive medicare supplemental insurance policy under chapter 48.66 RCW, the effect of any 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; ((~~and~~))

(v) Any person becoming eligible for medicare on or after August 1, 2009, who does not have access to a reasonable choice of comprehensive medicare part C plans, as defined in (b) of this subsection, and who provides evidence of (A) a rejection for medical reasons, (B) a requirement of restrictive riders, (C) an up-rated premium, (D) a preexisting conditions limitation, or (E) lack of access to or for a comprehensive medicare supplemental insurance policy under chapter 48.66 RCW, the effect of any 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; and

(vi) Any person under the age of nineteen who does not have access to individual plan open enrollment or special enrollment, as defined in RCW 48.43.005, at the time of application to the pool is eligible for the pool coverage, consistent with the requirements of the federal patient protection and affordable care act (P.L. 111-148) and the rules issued by the federal health and human services department (45 C.F.R. Sec. 145.103) and the insurance commissioner.

(b) For purposes of (a)(v) of this subsection (1), a person does not have access to a reasonable choice of plans unless the person has a choice of health maintenance organization or preferred provider organization medicare part C plans offered by at least three different carriers that have had provider networks in the person's county of residence for at least five years. The plan options must include coverage at least as comprehensive as a plan F medicare supplement plan combined with medicare parts A and B. The plan options must also provide access to adequate and stable provider networks that make up-to-date provider directories easily accessible on the carrier web site, and will provide them in hard copy, if requested. In addition, if no health maintenance organization or preferred provider organization plan

1 includes the health care provider with whom the person has an
2 established care relationship and from whom he or she has received
3 treatment within the past twelve months, the person does not have
4 reasonable access.

5 (2) The following persons are not eligible for coverage by the
6 pool:

7 (a) Any person having terminated coverage in the pool unless (i)
8 twelve months have lapsed since termination, or (ii) that person can
9 show continuous other coverage which has been involuntarily terminated
10 for any reason other than nonpayment of premiums. However, these
11 exclusions do not apply to eligible individuals as defined in section
12 2741(b) of the federal health insurance portability and accountability
13 act of 1996 (42 U.S.C. Sec. 300gg-41(b));

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

16 (c) Inmates of public institutions and those persons who become
17 eligible for medical assistance after June 30, 2008, as defined in RCW
18 74.09.010. However, these exclusions do not apply to eligible
19 individuals as defined in section 2741(b) of the federal health
20 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
21 300gg-41(b));

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

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

32 (a) If the health benefit plan offered is other than a catastrophic
33 health plan as defined in RCW 48.43.005, any person enrolled in a pool
34 plan pursuant to subsection (1)(a)(iii) of this section in that county
35 shall no longer be eligible for coverage under that plan pursuant to
36 subsection (1)(a)(iii) of this section, but may continue to be eligible
37 for pool coverage based upon the results of the standard health
38 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)(a)(iii) 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)(i), (ii), or (iv) 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)(a)(ii) of this section; and (iv) describe the enrollment process for the available options outside of the pool.

(4) The board shall ensure that an independent analysis of the eligibility standards for the pool coverage is conducted, including examining the eight percent eligibility threshold, eligibility for medicaid enrollees and other publicly sponsored enrollees, and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.

Sec. 6. RCW 48.41.110 and 2007 c 259 s 26 and 2007 c 8 s 5 are each reenacted and 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. The pool may incorporate managed care features into existing plans.

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

1 (3) The health insurance policies issued by the pool shall pay only
2 reasonable amounts for medically necessary eligible health care
3 services rendered or furnished for the diagnosis or treatment of
4 covered illnesses, injuries, and conditions. Eligible expenses are the
5 reasonable amounts for the health care services and items for which
6 benefits are extended under a pool policy.
7 (4) The pool shall offer at least two policies, one of which will
8 be a comprehensive policy that must comply with RCW 48.41.120 and must
9 at a minimum include the following services or related items:
10 (a) Hospital services, including charges for the most common
11 semiprivate room, for the most common private room if semiprivate rooms
12 do not exist in the health care facility, or for the private room if
13 medically necessary, including no less than a total of one hundred
14 eighty inpatient days in a calendar year, and no less than thirty days
15 inpatient care for alcohol, drug, or chemical dependency or abuse per
16 calendar year;
17 (b) Professional services including surgery for the treatment of
18 injuries, illnesses, or conditions, other than dental, which are
19 rendered by a health care provider, or at the direction of a health
20 care provider, by a staff of registered or licensed practical nurses,
21 or other health care providers;
22 (c) No less than twenty outpatient professional visits for the
23 diagnosis or treatment of alcohol, drug, or chemical dependency or
24 abuse rendered during a calendar year by a state-certified chemical
25 dependency program approved under chapter 70.96A RCW, or by one or more
26 physicians, psychologists, or community mental health professionals,
27 or, at the direction of a physician, by other qualified licensed health
28 care practitioners;
29 (d) Drugs and contraceptive devices requiring a prescription;
30 (e) Services of a skilled nursing facility, excluding custodial and
31 convalescent care, for not less than one hundred days in a calendar
32 year as prescribed by a physician;
33 (f) Services of a home health agency;
34 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine
35 therapy;
36 (h) Oxygen;
37 (i) Anesthesia services;
38 (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 including at least 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;

(r) Mental health services pursuant to RCW 48.41.220; and

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

(5) 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.

(6) 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. No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(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 (8) of this section.

(8)(a) Except as provided in (b) and (c) 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)).

(c) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen, consistent with the requirements of the federal patient protection and affordable care act (P.L. 111-148) and the rules issued by the federal health and human services department (45 C.F.R. Sec. 145.103) and the insurance commissioner.

(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.

(10) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to

1 participate. The pool may encourage the use of shared decision making
2 and certified decision aids for preference-sensitive care areas.

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