

CERTIFICATION OF ENROLLMENT

**HOUSE BILL 3154**

Chapter 80, Laws of 2000

56th Legislature  
2000 Regular Session

INDIVIDUAL HEALTH INSURANCE--TECHNICAL CORRECTIONS

EFFECTIVE DATE: 6/8/00

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

CLYDE BALLARD  
**Speaker of the House of  
Representatives**

FRANK CHOPP  
**Speaker of the House of  
Representatives**

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

BRAD OWEN  
**President of the Senate**

Approved March 23, 2000

GARY F. LOCKE  
**Governor of the State of Washington**

CERTIFICATE

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

CYNTHIA ZEHNDER  
**Chief Clerk**

TIMOTHY A. MARTIN  
**Chief Clerk**

FILED

March 23, 2000 - 11:42 a.m.

**Secretary of State  
State of Washington**

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HOUSE BILL 3154

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Passed Legislature - 2000 Regular Session

State of Washington                      56th Legislature                      2000 Regular Session

By Representatives Cody, Parlette, Conway, Clements, Campbell, Cairnes  
and Wood

Read first time 03/04/2000. Referred to Committee on .

1            AN ACT Relating to technical and clarifying corrections to chapter  
2   . . . (Engrossed Second Substitute Senate Bill No. 6067), Laws of 2000;  
3 amending RCW 48.41.040, 48.41.110, 48.43.015, 48.43.---, 41.05.140,  
4 41.05.---, and 48.21.015; and adding a new section to chapter 43.33A  
5 RCW.

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

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

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

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

1 representing each of the following: (a) Health care providers; (b)  
2 health insurance agents; (c) small employers; and (d) large employers.  
3 The governor shall select two members of the board from a list of  
4 nominees submitted by state-wide organizations representing health care  
5 consumers. In making these selections, the governor may request  
6 additional names from the state-wide organizations representing each of  
7 the persons to be selected if the governor chooses not to select a  
8 member from the list submitted. The remaining four members of the  
9 board shall be selected by election from among the members of the pool.  
10 The elected members shall, to the extent possible, include at least one  
11 representative of health care service contractors, one representative  
12 of health maintenance organizations, and one representative of  
13 commercial insurers which provides disability insurance. The members  
14 of the board shall elect a chair from the voting members of the board.  
15 The insurance commissioner shall be a nonvoting, ex officio member.  
16 When self-insured organizations other than the Washington state health  
17 care authority become eligible for participation in the pool, the  
18 membership of the board shall be increased to eleven and at least one  
19 member of the board shall 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  
39 pursuant to chapters 34.05 and 48.04 RCW, adopt such rules as are

1 necessary or advisable to effectuate this chapter. The rules shall  
2 continue in force until modified by the commissioner or superseded by  
3 a plan submitted by the board and approved by the commissioner.

4 **Sec. 2.** RCW 48.41.110 and 2000 c . . . (E2SSB 6067) s 13 are each  
5 amended to read as follows:

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

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

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

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

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

1 (c) The first twenty outpatient professional visits for the  
2 diagnosis or treatment of one or more mental or nervous conditions or  
3 alcohol, drug, or chemical dependency or abuse rendered during a  
4 calendar year by one or more physicians, psychologists, or community  
5 mental health professionals, or, at the direction of a physician, by  
6 other qualified licensed health care practitioners, in the case of  
7 mental or nervous conditions, and rendered by a state certified  
8 chemical dependency program approved under chapter 70.96A RCW, in the  
9 case of alcohol, drug, or chemical dependency or abuse;

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

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

14 (f) Services of a home health agency;

15 (g) Chemotherapy, radioisotope, radiation, and nuclear medicine  
16 therapy;

17 (h) Oxygen;

18 (i) Anesthesia services;

19 (j) Prostheses, other than dental;

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

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

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

30 (n) Maternity care services;

31 (o) Services of a physical therapist and services of a speech  
32 therapist;

33 (p) Hospice services;

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

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

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

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

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

27 (7)(a) Except as provided in (b) of this subsection, the pool shall  
28 credit any preexisting condition waiting period in its plans for a  
29 person who was enrolled at any time during the sixty-three day period  
30 immediately preceding the date of application for the new pool plan in  
31 a group health benefit plan or an individual health benefit plan other  
32 than a catastrophic health plan. The ((carrier)) pool must credit the  
33 period of coverage the person was continuously covered under the  
34 immediately preceding health plan toward the waiting period of the new  
35 health plan. For the purposes of this subsection, a preceding health  
36 plan includes an employer-provided self-funded health plan.

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

1 2741(b) of the federal health insurance portability and accountability  
2 act of 1996 (42 U.S.C. 300gg-41(b)).

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

5 (1) For a health benefit plan offered to a group other than a small  
6 group, every health carrier shall reduce any preexisting condition  
7 exclusion or limitation for persons or groups who had similar health  
8 coverage under a different health plan at any time during the three-  
9 month period immediately preceding the date of application for the new  
10 health plan if such person was continuously covered under the  
11 immediately preceding health plan. If the person was continuously  
12 covered for at least three months under the immediately preceding  
13 health plan, the carrier may not impose a waiting period for coverage  
14 of preexisting conditions. If the person was continuously covered for  
15 less than three months under the immediately preceding health plan, the  
16 carrier must credit any waiting period under the immediately preceding  
17 health plan toward the new health plan. For the purposes of this  
18 subsection, a preceding health plan includes an employer provided self-  
19 funded health plan and plans of the Washington state health insurance  
20 pool.

21 (2) For a health benefit plan offered to a small group, every  
22 health carrier shall reduce any preexisting condition exclusion or  
23 limitation for persons or groups who had similar health coverage under  
24 a different health plan at any time during the three-month period  
25 immediately preceding the date of application for the new health plan  
26 if such person was continuously covered under the immediately preceding  
27 health plan. If the person was continuously covered for at least nine  
28 months under the immediately preceding health plan, the carrier may not  
29 impose a waiting period for coverage of preexisting conditions. If the  
30 person was continuously covered for less than nine months under the  
31 immediately preceding health plan, the carrier must credit any waiting  
32 period under the immediately preceding health plan toward the new  
33 health plan. For the purposes of this subsection, a preceding health  
34 plan includes an employer provided self-funded health plan and plans of  
35 the Washington state health insurance pool.

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

1 that plan for a person who was enrolled at any time during the sixty-  
2 three day period immediately preceding the date of application for the  
3 new health plan in a group health benefit plan or an individual health  
4 benefit plan, other than a catastrophic health plan, and (a) the  
5 benefits under the previous plan provide equivalent or greater overall  
6 benefit coverage than that provided in the health benefit plan the  
7 individual seeks to purchase; or (b) the person is seeking an  
8 individual health benefit plan due to his or her change of residence  
9 from one geographic area in Washington state to another geographic area  
10 in Washington state where his or her current health plan is not  
11 offered, if application for coverage is made within ninety days of  
12 relocation; or (c) the person is seeking an individual health benefit  
13 plan: (i) Because a health care provider with whom he or she has an  
14 established care relationship and from whom he or she has received  
15 treatment within the past twelve months is no longer part of the  
16 carrier's provider network under his or her existing Washington  
17 individual health benefit plan; and (ii) his or her health care  
18 provider is part of another carrier's provider network; and (iii)  
19 application for a health benefit plan under that carrier's provider  
20 network individual coverage is made within ninety days of his or her  
21 provider leaving the previous carrier's provider network. The carrier  
22 must credit the period of coverage the person was continuously covered  
23 under the immediately preceding health plan toward the waiting period  
24 of the new health plan. For the purposes of this subsection (3), a  
25 preceding health plan includes an employer-provided self-funded health  
26 plan and plans of the Washington state health insurance pool.

27 (4) Every health carrier shall waive any preexisting condition  
28 waiting period in its individual plans for a person who is an eligible  
29 individual as defined in section 2741(b) of the federal health  
30 insurance portability and accountability act of 1996 (42 U.S.C. 300gg-  
31 41(b)).

32 (5) Subject to the provisions of subsections (1) through ((+3))  
33 (4) of this section, nothing contained in this section requires a  
34 health carrier to amend a health plan to provide new benefits in its  
35 existing health plans. In addition, nothing in this section requires  
36 a carrier to waive benefit limitations not related to an individual or  
37 group's preexisting conditions or health history.



1       **Sec. 4.** RCW 48.43.--- and 2000 c . . . (E2SSB 6067) s 21 are each  
2 amended to read as follows:

3       (1) Except as provided in (a) (~~(and (b))~~) through (c) 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.

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

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

37       (b) Within fifteen business days of receipt of a completed  
38 application, the carrier shall provide written notice of the decision  
39 not to accept the person's application for enrollment to both the

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

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

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

27 (1) Except for property and casualty insurance, the authority may  
28 self-fund, self-insure, or enter into other methods of providing  
29 insurance coverage for insurance programs under its jurisdiction,  
30 including the basic health plan as provided in chapter 70.47 RCW. The  
31 authority shall contract for payment of claims or other administrative  
32 services for programs under its jurisdiction. If a program does not  
33 require the prepayment of reserves, the authority shall establish such  
34 reserves within a reasonable period of time for the payment of claims  
35 as are normally required for that type of insurance under an insured  
36 program. The authority shall endeavor to reimburse basic health plan  
37 health care providers under this section at rates similar to the

1 average reimbursement rates offered by the state-wide benchmark plan  
2 determined through the request for proposal process.

3 (2) Reserves established by the authority for employee and retiree  
4 benefit programs shall be held in a separate trust fund by the state  
5 treasurer and shall be known as the public employees' and retirees'  
6 insurance reserve fund. The state investment board shall act as the  
7 investor for the funds and, except as provided in RCW 43.33A.160 and  
8 43.84.160, one hundred percent of all earnings from these investments  
9 shall accrue directly to the public employees' and retirees' insurance  
10 reserve fund.

11 (3) Any savings realized as a result of a program created for  
12 employees and retirees under this section shall not be used to increase  
13 benefits unless such use is authorized by statute.

14 (4) Reserves established by the authority to provide insurance  
15 coverage for the basic health plan under chapter 70.47 RCW shall be  
16 held in a separate trust account in the custody of the state treasurer  
17 and shall be known as the basic health plan self-insurance reserve  
18 account. The state investment board shall act as the investor for the  
19 funds (~~(and, except as provided in RCW 43.33A.160)~~) as set forth in  
20 section 6 of this act and, except as provided in RCW 43.33A.160 and  
21 43.84.160, one hundred percent of all earnings from these investments  
22 shall accrue directly to the basic health plan self-insurance reserve  
23 account.

24 (5) Any program created under this section shall be subject to the  
25 examination requirements of chapter 48.03 RCW as if the program were a  
26 domestic insurer. In conducting an examination, the commissioner shall  
27 determine the adequacy of the reserves established for the program.

28 (6) The authority shall keep full and adequate accounts and records  
29 of the assets, obligations, transactions, and affairs of any program  
30 created under this section.

31 (7) The authority shall file a quarterly statement of the financial  
32 condition, transactions, and affairs of any program created under this  
33 section in a form and manner prescribed by the insurance commissioner.  
34 The statement shall contain information as required by the commissioner  
35 for the type of insurance being offered under the program. A copy of  
36 the annual statement shall be filed with the speaker of the house of  
37 representatives and the president of the senate.

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

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

10       (2)    All investments made by the state investment board shall be  
11 made with the exercise of that degree of judgment and care under RCW  
12 43.33A.140 and the investment policy established by the state  
13 investment board.

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

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

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

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

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

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

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

33       (c)    Deductibles of three thousand dollars on a per person per  
34 calendar year basis, and four thousand dollars on a per family per  
35 calendar year basis. The deductible shall be applied to the first  
36 three thousand dollars, or four thousand dollars, of eligible expenses  
37 incurred by the covered person or family, respectively, except that the  
38 deductible shall not be applied to clinical preventive services as

1 recommended by the United States public health service. Enrollee out-  
2 of-pocket expenses required to be paid under the plan for cost-sharing  
3 and deductibles shall not exceed five thousand dollars per person, or  
4 six thousand dollars per family;

5 (d) Payment methodologies for network providers may include but are  
6 not limited to resource-based relative value fee schedules, capitation  
7 payments, diagnostic related group fee schedules, and other similar  
8 strategies including risk-sharing arrangements; and

9 (e) Other appropriate care management and cost-containment measures  
10 determined appropriate by the administrator, including but not limited  
11 to care coordination, provider network limitations, preadmission  
12 certification, and utilization review.

13 (3) Any person is eligible for coverage in the plan who resides in  
14 a county of the state where no carrier, as defined in RCW 48.43.005, or  
15 insurer regulated under chapter 48.15 RCW offers to the public an  
16 individual health benefit plan as defined in RCW 48.43.005 other than  
17 a catastrophic health plan as defined in RCW 48.43.005 at the time of  
18 application to the administrator. Such eligibility may terminate  
19 pursuant to subsection ~~((7))~~ (8) of this section.

20 (4) The administrator may not reject an individual for coverage  
21 based upon preexisting conditions of the individual or deny, exclude,  
22 or otherwise limit coverage for an individual's preexisting health  
23 conditions; except that it shall impose a nine-month benefit waiting  
24 period for preexisting conditions for which medical advice was given,  
25 or for which a health care provider recommended or provided treatment,  
26 or for which a prudent layperson would have sought advice or treatment,  
27 within six months before the effective date of coverage. The  
28 preexisting condition waiting period shall not apply to prenatal care  
29 services. Credit against the waiting period shall be provided pursuant  
30 to subsections (5) and (6) of this section.

31 (5) Except for persons to whom subsection (6) of this section  
32 applies, the administrator shall credit any preexisting condition  
33 waiting period in the plan for a person who was enrolled at any time  
34 during the sixty-three day period immediately preceding the date of  
35 application for the plan in a group health benefit plan or an  
36 individual health benefit plan other than a catastrophic health plan.  
37 The administrator must credit the period of coverage the person was  
38 continuously covered under the immediately preceding health plan toward  
39 the waiting period of the new health plan. For the purposes of this

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

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

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

9 ((+7)) (8) When a carrier, as defined in RCW 48.43.005, or an  
10 insurer regulated under chapter 48.15 RCW, begins to offer an  
11 individual health benefit plan as defined in RCW 48.43.005 in a county  
12 where no carrier or insurer had been offering an individual health  
13 benefit plan:

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

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

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

27 Group stop loss insurance is exempt from all sections of this  
28 chapter((7)) and chapter 48.32A RCW((, and chapter 48.41 RCW)) except  
29 for RCW 48.21.010 and this section. For (({the}) the purpose of this  
30 exemption, group stop loss is further defined as follows:

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

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

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

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

Passed the House March 4, 2000.

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