

CERTIFICATION OF ENROLLMENT
ENGROSSED SUBSTITUTE HOUSE BILL 2797

Chapter 192, Laws of 2004

58th Legislature
2004 Regular Session

BASIC HEALTH PLAN ACCESS

EFFECTIVE DATE: 1/1/05

Passed by the House March 11, 2004
Yeas 96 Nays 0

FRANK CHOPP

Speaker of the House of Representatives

Passed by the Senate March 11, 2004
Yeas 49 Nays 0

BRAD OWEN

President of the Senate

Approved March 26, 2004.

GARY F. LOCKE

Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE HOUSE BILL 2797** as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER

Chief Clerk

FILED

March 26, 2004 - 4:51 p.m.

**Secretary of State
State of Washington**

ENGROSSED SUBSTITUTE HOUSE BILL 2797

AS AMENDED BY THE SENATE

Passed Legislature - 2004 Regular Session

State of Washington 58th Legislature 2004 Regular Session

By House Committee on Health Care (originally sponsored by Representatives Morrell, Cody, Linville, Simpson, G., Edwards, Kenney and Ormsby; by request of Insurance Commissioner)

READ FIRST TIME 02/06/04.

1 AN ACT Relating to providing access to the basic health plan for
2 individuals eligible for the health coverage tax credit under the Trade
3 Act of 2002 (P.L. 107-210); amending RCW 70.47.020, 70.47.030,
4 70.47.060, 70.47.100, and 48.43.015; and providing an effective date.

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

6 **Sec. 1.** RCW 70.47.020 and 2000 c 79 s 43 are each amended to read
7 as follows:

8 As used in this chapter:

9 (1) "Washington basic health plan" or "plan" means the system of
10 enrollment and payment for basic health care services, administered by
11 the plan administrator through participating managed health care
12 systems, created by this chapter.

13 (2) "Administrator" means the Washington basic health plan
14 administrator, who also holds the position of administrator of the
15 Washington state health care authority.

16 (3) "Health coverage tax credit program" means the program created
17 by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax
18 credit that subsidizes private health insurance coverage for displaced

1 workers certified to receive certain trade adjustment assistance
2 benefits and for individuals receiving benefits from the pension
3 benefit guaranty corporation.

4 (4) "Health coverage tax credit eligible enrollee" means individual
5 workers and their qualified family members who lose their jobs due to
6 the effects of international trade and are eligible for certain trade
7 adjustment assistance benefits; or are eligible for benefits under the
8 alternative trade adjustment assistance program; or are people who
9 receive benefits from the pension benefit guaranty corporation and are
10 at least fifty-five years old.

11 (5) "Managed health care system" means: (a) Any health care
12 organization, including health care providers, insurers, health care
13 service contractors, health maintenance organizations, or any
14 combination thereof, that provides directly or by contract basic health
15 care services, as defined by the administrator and rendered by duly
16 licensed providers, to a defined patient population enrolled in the
17 plan and in the managed health care system; or (b) a self-funded or
18 self-insured method of providing insurance coverage to subsidized
19 enrollees provided under RCW 41.05.140 and subject to the limitations
20 under RCW 70.47.100(7).

21 ~~((4))~~ (6) "Subsidized enrollee" means an individual, or an
22 individual plus the individual's spouse or dependent children: (a) Who
23 is not eligible for medicare; (b) who is not confined or residing in a
24 government-operated institution, unless he or she meets eligibility
25 criteria adopted by the administrator; (c) who resides in an area of
26 the state served by a managed health care system participating in the
27 plan; (d) whose gross family income at the time of enrollment does not
28 exceed two hundred percent of the federal poverty level as adjusted for
29 family size and determined annually by the federal department of health
30 and human services; and (e) who chooses to obtain basic health care
31 coverage from a particular managed health care system in return for
32 periodic payments to the plan. To the extent that state funds are
33 specifically appropriated for this purpose, with a corresponding
34 federal match, "subsidized enrollee" also means an individual, or an
35 individual's spouse or dependent children, who meets the requirements
36 in (a) through (c) and (e) of this subsection and whose gross family
37 income at the time of enrollment is more than two hundred percent, but

1 less than two hundred fifty-one percent, of the federal poverty level
2 as adjusted for family size and determined annually by the federal
3 department of health and human services.

4 ~~((+5))~~ (7) "Nonsubsidized enrollee" means an individual, or an
5 individual plus the individual's spouse or dependent children: (a) Who
6 is not eligible for medicare; (b) who is not confined or residing in a
7 government-operated institution, unless he or she meets eligibility
8 criteria adopted by the administrator; (c) who resides in an area of
9 the state served by a managed health care system participating in the
10 plan; (d) who chooses to obtain basic health care coverage from a
11 particular managed health care system; and (e) who pays or on whose
12 behalf is paid the full costs for participation in the plan, without
13 any subsidy from the plan.

14 ~~((+6))~~ (8) "Subsidy" means the difference between the amount of
15 periodic payment the administrator makes to a managed health care
16 system on behalf of a subsidized enrollee plus the administrative cost
17 to the plan of providing the plan to that subsidized enrollee, and the
18 amount determined to be the subsidized enrollee's responsibility under
19 RCW 70.47.060(2).

20 ~~((+7))~~ (9) "Premium" means a periodic payment, based upon gross
21 family income which an individual, their employer or another financial
22 sponsor makes to the plan as consideration for enrollment in the plan
23 as a subsidized enrollee ~~((or))~~, a nonsubsidized enrollee, or a health
24 coverage tax credit eligible enrollee.

25 ~~((+8))~~ (10) "Rate" means the amount, negotiated by the
26 administrator with and paid to a participating managed health care
27 system, that is based upon the enrollment of subsidized ~~((and))~~,
28 nonsubsidized, and health coverage tax credit eligible enrollees in the
29 plan and in that system.

30 **Sec. 2.** RCW 70.47.030 and 1995 2nd sp.s. c 18 s 913 are each
31 amended to read as follows:

32 (1) The basic health plan trust account is hereby established in
33 the state treasury. Any nongeneral fund-state funds collected for this
34 program shall be deposited in the basic health plan trust account and
35 may be expended without further appropriation. Moneys in the account
36 shall be used exclusively for the purposes of this chapter, including

1 payments to participating managed health care systems on behalf of
2 enrollees in the plan and payment of costs of administering the plan.

3 During the 1995-97 fiscal biennium, the legislature may transfer
4 funds from the basic health plan trust account to the state general
5 fund.

6 (2) The basic health plan subscription account is created in the
7 custody of the state treasurer. All receipts from amounts due from or
8 on behalf of nonsubsidized enrollees and health coverage tax credit
9 eligible enrollees shall be deposited into the account. Funds in the
10 account shall be used exclusively for the purposes of this chapter,
11 including payments to participating managed health care systems on
12 behalf of nonsubsidized enrollees and health coverage tax credit
13 eligible enrollees in the plan and payment of costs of administering
14 the plan. The account is subject to allotment procedures under chapter
15 43.88 RCW, but no appropriation is required for expenditures.

16 (3) The administrator shall take every precaution to see that none
17 of the funds in the separate accounts created in this section or that
18 any premiums paid either by subsidized or nonsubsidized enrollees are
19 commingled in any way, except that the administrator may combine funds
20 designated for administration of the plan into a single administrative
21 account.

22 **Sec. 3.** RCW 70.47.060 and 2001 c 196 s 13 are each amended to read
23 as follows:

24 The administrator has the following powers and duties:

25 (1) To design and from time to time revise a schedule of covered
26 basic health care services, including physician services, inpatient and
27 outpatient hospital services, prescription drugs and medications, and
28 other services that may be necessary for basic health care. In
29 addition, the administrator may, to the extent that funds are
30 available, offer as basic health plan services chemical dependency
31 services, mental health services and organ transplant services;
32 however, no one service or any combination of these three services
33 shall increase the actuarial value of the basic health plan benefits by
34 more than five percent excluding inflation, as determined by the office
35 of financial management. All subsidized and nonsubsidized enrollees in
36 any participating managed health care system under the Washington basic
37 health plan shall be entitled to receive covered basic health care

1 services in return for premium payments to the plan. The schedule of
2 services shall emphasize proven preventive and primary health care and
3 shall include all services necessary for prenatal, postnatal, and well-
4 child care. However, with respect to coverage for subsidized enrollees
5 who are eligible to receive prenatal and postnatal services through the
6 medical assistance program under chapter 74.09 RCW, the administrator
7 shall not contract for such services except to the extent that such
8 services are necessary over not more than a one-month period in order
9 to maintain continuity of care after diagnosis of pregnancy by the
10 managed care provider. The schedule of services shall also include a
11 separate schedule of basic health care services for children, eighteen
12 years of age and younger, for those subsidized or nonsubsidized
13 enrollees who choose to secure basic coverage through the plan only for
14 their dependent children. In designing and revising the schedule of
15 services, the administrator shall consider the guidelines for assessing
16 health services under the mandated benefits act of 1984, RCW 48.47.030,
17 and such other factors as the administrator deems appropriate.

18 (2)(a) To design and implement a structure of periodic premiums due
19 the administrator from subsidized enrollees that is based upon gross
20 family income, giving appropriate consideration to family size and the
21 ages of all family members. The enrollment of children shall not
22 require the enrollment of their parent or parents who are eligible for
23 the plan. The structure of periodic premiums shall be applied to
24 subsidized enrollees entering the plan as individuals pursuant to
25 subsection (~~((9))~~) (11) of this section and to the share of the cost of
26 the plan due from subsidized enrollees entering the plan as employees
27 pursuant to subsection (~~((10))~~) (12) of this section.

28 (b) To determine the periodic premiums due the administrator from
29 nonsubsidized enrollees. Premiums due from nonsubsidized enrollees
30 shall be in an amount equal to the cost charged by the managed health
31 care system provider to the state for the plan plus the administrative
32 cost of providing the plan to those enrollees and the premium tax under
33 RCW 48.14.0201.

34 To determine the periodic premiums due the administrator from
35 health coverage tax credit eligible enrollees. Premiums due from
36 health coverage tax credit eligible enrollees must be in an amount
37 equal to the cost charged by the managed health care system provider to
38 the state for the plan, plus the administrative cost of providing the

1 plan to those enrollees and the premium tax under RCW 48.14.0201. The
2 administrator will consider the impact of eligibility determination by
3 the appropriate federal agency designated by the Trade Act of 2002
4 (P.L. 107-210) as well as the premium collection and remittance
5 activities by the United States internal revenue service when
6 determining the administrative cost charged for health coverage tax
7 credit eligible enrollees.

8 (d) An employer or other financial sponsor may, with the prior
9 approval of the administrator, pay the premium, rate, or any other
10 amount on behalf of a subsidized or nonsubsidized enrollee, by
11 arrangement with the enrollee and through a mechanism acceptable to the
12 administrator. The administrator shall establish a mechanism for
13 receiving premium payments from the United States internal revenue
14 service for health coverage tax credit eligible enrollees.

15 ((+d)) (e) To develop, as an offering by every health carrier
16 providing coverage identical to the basic health plan, as configured on
17 January 1, 2001, a basic health plan model plan with uniformity in
18 enrollee cost-sharing requirements.

19 (3) To evaluate, with the cooperation of participating managed
20 health care system providers, the impact on the basic health plan of
21 enrolling health coverage tax credit eligible enrollees. The
22 administrator shall issue to the appropriate committees of the
23 legislature preliminary evaluations on June 1, 2005, and January 1,
24 2006, and a final evaluation by June 1, 2006. The evaluation shall
25 address the number of persons enrolled, the duration of their
26 enrollment, their utilization of covered services relative to other
27 basic health plan enrollees, and the extent to which their enrollment
28 contributed to any change in the cost of the basic health plan.

29 (4) To end the participation of health coverage tax credit eligible
30 enrollees in the basic health plan if the federal government reduces or
31 terminates premium payments on their behalf through the United States
32 internal revenue service.

33 (5) To design and implement a structure of enrollee cost-sharing
34 due a managed health care system from subsidized ((and)),
35 nonsubsidized, and health coverage tax credit eligible enrollees. The
36 structure shall discourage inappropriate enrollee utilization of health
37 care services, and may utilize copayments, deductibles, and other cost-

1 sharing mechanisms, but shall not be so costly to enrollees as to
2 constitute a barrier to appropriate utilization of necessary health
3 care services.

4 ~~((+4))~~ (6) To limit enrollment of persons who qualify for
5 subsidies so as to prevent an overexpenditure of appropriations for
6 such purposes. Whenever the administrator finds that there is danger
7 of such an overexpenditure, the administrator shall close enrollment
8 until the administrator finds the danger no longer exists. Such a
9 closure does not apply to health coverage tax credit eligible enrollees
10 who receive a premium subsidy from the United States internal revenue
11 service as long as the enrollees qualify for the health coverage tax
12 credit program.

13 ~~((+5))~~ (7) To limit the payment of subsidies to subsidized
14 enrollees, as defined in RCW 70.47.020. The level of subsidy provided
15 to persons who qualify may be based on the lowest cost plans, as
16 defined by the administrator.

17 ~~((+6))~~ (8) To adopt a schedule for the orderly development of the
18 delivery of services and availability of the plan to residents of the
19 state, subject to the limitations contained in RCW 70.47.080 or any act
20 appropriating funds for the plan.

21 ~~((+7))~~ (9) To solicit and accept applications from managed health
22 care systems, as defined in this chapter, for inclusion as eligible
23 basic health care providers under the plan for ~~((either))~~ subsidized
24 enrollees, ~~((or))~~ nonsubsidized enrollees, or ~~((both))~~ health coverage
25 tax credit eligible enrollees. The administrator shall endeavor to
26 assure that covered basic health care services are available to any
27 enrollee of the plan from among a selection of two or more
28 participating managed health care systems. In adopting any rules or
29 procedures applicable to managed health care systems and in its
30 dealings with such systems, the administrator shall consider and make
31 suitable allowance for the need for health care services and the
32 differences in local availability of health care resources, along with
33 other resources, within and among the several areas of the state.
34 Contracts with participating managed health care systems shall ensure
35 that basic health plan enrollees who become eligible for medical
36 assistance may, at their option, continue to receive services from
37 their existing providers within the managed health care system if such

1 providers have entered into provider agreements with the department of
2 social and health services.

3 ~~((+8))~~ (10) To receive periodic premiums from or on behalf of
4 subsidized ~~((and))~~, nonsubsidized, and health coverage tax credit
5 eligible enrollees, deposit them in the basic health plan operating
6 account, keep records of enrollee status, and authorize periodic
7 payments to managed health care systems on the basis of the number of
8 enrollees participating in the respective managed health care systems.

9 ~~((+9))~~ (11) To accept applications from individuals residing in
10 areas served by the plan, on behalf of themselves and their spouses and
11 dependent children, for enrollment in the Washington basic health plan
12 as subsidized ~~((or))~~, nonsubsidized, or health coverage tax credit
13 eligible enrollees, to establish appropriate minimum-enrollment periods
14 for enrollees as may be necessary, and to determine, upon application
15 and on a reasonable schedule defined by the authority, or at the
16 request of any enrollee, eligibility due to current gross family income
17 for sliding scale premiums. Funds received by a family as part of
18 participation in the adoption support program authorized under RCW
19 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward
20 a family's current gross family income for the purposes of this
21 chapter. When an enrollee fails to report income or income changes
22 accurately, the administrator shall have the authority either to bill
23 the enrollee for the amounts overpaid by the state or to impose civil
24 penalties of up to two hundred percent of the amount of subsidy
25 overpaid due to the enrollee incorrectly reporting income. The
26 administrator shall adopt rules to define the appropriate application
27 of these sanctions and the processes to implement the sanctions
28 provided in this subsection, within available resources. No subsidy
29 may be paid with respect to any enrollee whose current gross family
30 income exceeds twice the federal poverty level or, subject to RCW
31 70.47.110, who is a recipient of medical assistance or medical care
32 services under chapter 74.09 RCW. If a number of enrollees drop their
33 enrollment for no apparent good cause, the administrator may establish
34 appropriate rules or requirements that are applicable to such
35 individuals before they will be allowed to reenroll in the plan.

36 ~~((+10))~~ (12) To accept applications from business owners on behalf
37 of themselves and their employees, spouses, and dependent children, as
38 subsidized or nonsubsidized enrollees, who reside in an area served by

1 the plan. The administrator may require all or the substantial
2 majority of the eligible employees of such businesses to enroll in the
3 plan and establish those procedures necessary to facilitate the orderly
4 enrollment of groups in the plan and into a managed health care system.
5 The administrator may require that a business owner pay at least an
6 amount equal to what the employee pays after the state pays its portion
7 of the subsidized premium cost of the plan on behalf of each employee
8 enrolled in the plan. Enrollment is limited to those not eligible for
9 medicare who wish to enroll in the plan and choose to obtain the basic
10 health care coverage and services from a managed care system
11 participating in the plan. The administrator shall adjust the amount
12 determined to be due on behalf of or from all such enrollees whenever
13 the amount negotiated by the administrator with the participating
14 managed health care system or systems is modified or the administrative
15 cost of providing the plan to such enrollees changes.

16 ~~((+11+))~~ (13) To determine the rate to be paid to each
17 participating managed health care system in return for the provision of
18 covered basic health care services to enrollees in the system.
19 Although the schedule of covered basic health care services will be the
20 same or actuarially equivalent for similar enrollees, the rates
21 negotiated with participating managed health care systems may vary
22 among the systems. In negotiating rates with participating systems,
23 the administrator shall consider the characteristics of the populations
24 served by the respective systems, economic circumstances of the local
25 area, the need to conserve the resources of the basic health plan trust
26 account, and other factors the administrator finds relevant.

27 ~~((+12+))~~ (14) To monitor the provision of covered services to
28 enrollees by participating managed health care systems in order to
29 assure enrollee access to good quality basic health care, to require
30 periodic data reports concerning the utilization of health care
31 services rendered to enrollees in order to provide adequate information
32 for evaluation, and to inspect the books and records of participating
33 managed health care systems to assure compliance with the purposes of
34 this chapter. In requiring reports from participating managed health
35 care systems, including data on services rendered enrollees, the
36 administrator shall endeavor to minimize costs, both to the managed
37 health care systems and to the plan. The administrator shall

1 coordinate any such reporting requirements with other state agencies,
2 such as the insurance commissioner and the department of health, to
3 minimize duplication of effort.

4 ~~((13))~~ (15) To evaluate the effects this chapter has on private
5 employer- based health care coverage and to take appropriate measures
6 consistent with state and federal statutes that will discourage the
7 reduction of such coverage in the state.

8 ~~((14))~~ (16) To develop a program of proven preventive health
9 measures and to integrate it into the plan wherever possible and
10 consistent with this chapter.

11 ~~((15))~~ (17) To provide, consistent with available funding,
12 assistance for rural residents, underserved populations, and persons of
13 color.

14 ~~((16))~~ (18) In consultation with appropriate state and local
15 government agencies, to establish criteria defining eligibility for
16 persons confined or residing in government-operated institutions.

17 ~~((17))~~ (19) To administer the premium discounts provided under
18 RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the
19 Washington state health insurance pool.

20 **Sec. 4.** RCW 70.47.100 and 2000 c 79 s 35 are each amended to read
21 as follows:

22 (1) A managed health care system participating in the plan shall do
23 so by contract with the administrator and shall provide, directly or by
24 contract with other health care providers, covered basic health care
25 services to each enrollee covered by its contract with the
26 administrator as long as payments from the administrator on behalf of
27 the enrollee are current. A participating managed health care system
28 may offer, without additional cost, health care benefits or services
29 not included in the schedule of covered services under the plan. A
30 participating managed health care system shall not give preference in
31 enrollment to enrollees who accept such additional health care benefits
32 or services. Managed health care systems participating in the plan
33 shall not discriminate against any potential or current enrollee based
34 upon health status, sex, race, ethnicity, or religion. The
35 administrator may receive and act upon complaints from enrollees
36 regarding failure to provide covered services or efforts to obtain
37 payment, other than authorized copayments, for covered services

1 directly from enrollees, but nothing in this chapter empowers the
2 administrator to impose any sanctions under Title 18 RCW or any other
3 professional or facility licensing statute.

4 (2) The plan shall allow, at least annually, an opportunity for
5 enrollees to transfer their enrollments among participating managed
6 health care systems serving their respective areas. The administrator
7 shall establish a period of at least twenty days in a given year when
8 this opportunity is afforded enrollees, and in those areas served by
9 more than one participating managed health care system the
10 administrator shall endeavor to establish a uniform period for such
11 opportunity. The plan shall allow enrollees to transfer their
12 enrollment to another participating managed health care system at any
13 time upon a showing of good cause for the transfer.

14 (3) Prior to negotiating with any managed health care system, the
15 administrator shall determine, on an actuarially sound basis, the
16 reasonable cost of providing the schedule of basic health care
17 services, expressed in terms of upper and lower limits, and recognizing
18 variations in the cost of providing the services through the various
19 systems and in different areas of the state.

20 (4) In negotiating with managed health care systems for
21 participation in the plan, the administrator shall adopt a uniform
22 procedure that includes at least the following:

23 (a) The administrator shall issue a request for proposals,
24 including standards regarding the quality of services to be provided;
25 financial integrity of the responding systems; and responsiveness to
26 the unmet health care needs of the local communities or populations
27 that may be served;

28 (b) The administrator shall then review responsive proposals and
29 may negotiate with respondents to the extent necessary to refine any
30 proposals;

31 (c) The administrator may then select one or more systems to
32 provide the covered services within a local area; and

33 (d) The administrator may adopt a policy that gives preference to
34 respondents, such as nonprofit community health clinics, that have a
35 history of providing quality health care services to low-income
36 persons.

37 (5) The administrator may contract with a managed health care

1 system to provide covered basic health care services to (~~either~~)
2 subsidized enrollees, (~~or~~) nonsubsidized enrollees, health coverage
3 tax credit eligible enrollees, or (~~both~~) any combination thereof.

4 (6) The administrator may establish procedures and policies to
5 further negotiate and contract with managed health care systems
6 following completion of the request for proposal process in subsection
7 (4) of this section, upon a determination by the administrator that it
8 is necessary to provide access, as defined in the request for proposal
9 documents, to covered basic health care services for enrollees.

10 (7)(a) The administrator shall implement a self-funded or self-
11 insured method of providing insurance coverage to subsidized enrollees,
12 as provided under RCW 41.05.140, if one of the following conditions is
13 met:

14 (i) The authority determines that no managed health care system
15 other than the authority is willing and able to provide access, as
16 defined in the request for proposal documents, to covered basic health
17 care services for all subsidized enrollees in an area; or

18 (ii) The authority determines that no other managed health care
19 system is willing to provide access, as defined in the request for
20 proposal documents, for one hundred thirty-three percent of the
21 statewide benchmark price or less, and the authority is able to offer
22 such coverage at a price that is less than the lowest price at which
23 any other managed health care system is willing to provide such access
24 in an area.

25 (b) The authority shall initiate steps to provide the coverage
26 described in (a) of this subsection within ninety days of making its
27 determination that the conditions for providing a self-funded or self-
28 insured method of providing insurance have been met.

29 (c) The administrator may not implement a self-funded or self-
30 insured method of providing insurance in an area unless the
31 administrator has received a certification from a member of the
32 American academy of actuaries that the funding available in the basic
33 health plan self-insurance reserve account is sufficient for the self-
34 funded or self-insured risk assumed, or expected to be assumed, by the
35 administrator.

36 **Sec. 5.** RCW 48.43.015 and 2001 c 196 s 7 are each amended to read
37 as follows:

1 (1) For a health benefit plan offered to a group, every health
2 carrier shall reduce any preexisting condition exclusion, limitation,
3 or waiting period in the group health plan in accordance with the
4 provisions of section 2701 of the federal health insurance portability
5 and accountability act of 1996 (42 U.S.C. Sec. 300gg).

6 (2) For a health benefit plan offered to a group other than a small
7 group:

8 (a) If the individual applicant's immediately preceding health plan
9 coverage terminated during the period beginning ninety days and ending
10 sixty-four days before the date of application for the new plan and
11 such coverage was similar and continuous for at least three months,
12 then the carrier shall not impose a waiting period for coverage of
13 preexisting conditions under the new health plan.

14 (b) If the individual applicant's immediately preceding health plan
15 coverage terminated during the period beginning ninety days and ending
16 sixty-four days before the date of application for the new plan and
17 such coverage was similar and continuous for less than three months,
18 then the carrier shall credit the time covered under the immediately
19 preceding health plan toward any preexisting condition waiting period
20 under the new health plan.

21 (c) For the purposes of this subsection, a preceding health plan
22 includes an employer-provided self-funded health plan, the basic health
23 plan's offering to health coverage tax credit eligible enrollees as
24 established by this act, and plans of the Washington state health
25 insurance pool.

26 (3) For a health benefit plan offered to a small group:

27 (a) If the individual applicant's immediately preceding health plan
28 coverage terminated during the period beginning ninety days and ending
29 sixty-four days before the date of application for the new plan and
30 such coverage was similar and continuous for at least nine months, then
31 the carrier shall not impose a waiting period for coverage of
32 preexisting conditions under the new health plan.

33 (b) If the individual applicant's immediately preceding health plan
34 coverage terminated during the period beginning ninety days and ending
35 sixty-four days before the date of application for the new plan and
36 such coverage was similar and continuous for less than nine months,
37 then the carrier shall credit the time covered under the immediately

1 preceding health plan toward any preexisting condition waiting period
2 under the new health plan.

3 (c) For the purpose of this subsection, a preceding health plan
4 includes an employer-provided self-funded health plan, the basic health
5 plan's offering to health coverage tax credit eligible enrollees as
6 established by this act, and plans of the Washington state health
7 insurance pool.

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

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

6 (6) Subject to the provisions of subsections (1) through (5) of
7 this section, nothing contained in this section requires a health
8 carrier to amend a health plan to provide new benefits in its existing
9 health plans. In addition, nothing in this section requires a carrier
10 to waive benefit limitations not related to an individual or group's
11 preexisting conditions or health history.

12 NEW SECTION. **Sec. 6.** This act takes effect January 1, 2005.

Passed by the House March 11, 2004.

Passed by the Senate March 11, 2004.

Approved by the Governor March 26, 2004.

Filed in Office of Secretary of State March 26, 2004.