CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE SENATE BILL 5371

Chapter 315, Laws of 2011

62nd Legislature
2011 Regular Session

HEALTH INSURANCE--PERSONS UNDER NINETEEN

EFFECTIVE DATE: 07/22/11 - Except sections 5 and 6, which become effective 05/11/11.

Passed by the Senate April 18, 2011
YEAS 48 NAYS 0

BRAD OWEN

President of the Senate

Passed by the House April 7, 2011
YEAS 90 NAYS 2

FRANK CHOPP

Speaker of the House of Representatives

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE SENATE BILL 5371** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

Approved May 11, 2011, 2:00 p.m.

FILED

May 11, 2011

CHRISTINE GREGOIRE

Governor of the State of Washington

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE SENATE BILL 5371

AS AMENDED BY THE HOUSE

Passed Legislature - 2011 Regular Session

State of Washington 62nd Legislature 2011 Regular Session

By Senate Health & Long-Term Care (originally sponsored by Senators Keiser and Conway)

READ FIRST TIME 02/08/11.

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; creating a new section; and declaring an emergency.

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 direction for the implementation of the new policy requirement, and the
12 office of the 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; and
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.

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.

1 ((~~(13)~~)) (14) "Enrollee point-of-service cost-sharing" means
2 amounts paid to health carriers directly providing services, health
3 care providers, or health care facilities by enrollees and may include
4 copayments, coinsurance, or deductibles.

5 ((~~(14)~~)) (15) "Grievance" means a written complaint submitted by or
6 on behalf of a covered person regarding: (a) Denial of payment for
7 medical services or nonprovision of medical services included in the
8 covered person's health benefit plan, or (b) service delivery issues
9 other than denial of payment for medical services or nonprovision of
10 medical services, including dissatisfaction with medical care, waiting
11 time for medical services, provider or staff attitude or demeanor, or
12 dissatisfaction with service provided by the health carrier.

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

26 ((~~(16)~~)) (17) "Health care provider" or "provider" means:

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

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

32 ((~~(17)~~)) (18) "Health care service" means that service offered or
33 provided by health care facilities and health care providers relating
34 to the prevention, cure, or treatment of illness, injury, or disease.

35 ((~~(18)~~)) (19) "Health carrier" or "carrier" means a disability
36 insurer regulated under chapter 48.20 or 48.21 RCW, a health care
37 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 education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

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

((~~(21)~~)) (22) "Open enrollment" means a period of time as defined in rule to be held at the same time each year, during which applicants

may enroll in a 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.

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

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

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

((~~(24)~~)) (26) "Small employer" or "small group" means any person, firm, corporation, partnership, association, political subdivision, sole proprietor, or self-employed individual that is actively engaged in business that employed an average of at least one but no more than fifty employees, during the previous calendar year and employed at least one employee on the first day of the plan year, is not formed primarily for purposes of buying health insurance, and in which a bona fide employer-employee relationship exists. In determining the number of employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this 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 for the purpose of improving enrollee health status and reducing health service costs.

Sec. 3. RCW 48.43.012 and 2001 c 196 s 6 are each amended to read as follows:

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

(2) No carrier may deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions except as provided in this section.

(3) For an individual health benefit plan originally issued on or after March 23, 2000, preexisting condition waiting periods imposed upon a person enrolling in an individual health benefit plan shall be no more than nine months for a preexisting condition 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 prior to the effective date of the plan. No carrier may impose a preexisting condition waiting period on an individual health benefit plan issued to 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)).

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

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

(6) For any person under age nineteen applying for coverage as allowed by section 4(1) of this act or enrolled in a health benefit plan subject to sections 1201 and 10103 of the patient protection and affordable care act (P.L. 111-148) that is not a grandfathered health plan in the individual market, a carrier must not impose a preexisting condition exclusion or waiting period or other limitations on benefits or enrollment due to a preexisting condition.

NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW to read as follows:

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

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

Sec. 5. RCW 48.41.100 and 2009 c 555 s 3 are each amended to read as follows:

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

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

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

(iii) Any person who resides in a county of the state where no carrier or insurer eligible under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to 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, or the federal preexisting condition insurance pool, at the time of application to the pool is eligible for the pool coverage.

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

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

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

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

1 (c) Inmates of public institutions and those persons who become
2 eligible for medical assistance after June 30, 2008, as defined in RCW
3 74.09.010. However, these exclusions do not apply to eligible
4 individuals as defined in section 2741(b) of the federal health
5 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
6 300gg-41(b));
7 (d) Any person who resides in a county of the state where any
8 carrier or insurer regulated under chapter 48.15 RCW offers to the
9 public an individual health benefit plan other than a catastrophic
10 health plan as defined in RCW 48.43.005 at the time of application to
11 the pool and who does not qualify for pool coverage based upon the
12 results of the standard health questionnaire, or pursuant to subsection
13 (1)(a)(iv) of this section.
14 (3) When a carrier or insurer regulated under chapter 48.15 RCW
15 begins to offer an individual health benefit plan in a county where no
16 carrier had been offering an individual health benefit plan:
17 (a) If the health benefit plan offered is other than a catastrophic
18 health plan as defined in RCW 48.43.005, any person enrolled in a pool
19 plan pursuant to subsection (1)(a)(iii) of this section in that county
20 shall no longer be eligible for coverage under that plan pursuant to
21 subsection (1)(a)(iii) of this section, but may continue to be eligible
22 for pool coverage based upon the results of the standard health
23 questionnaire designated by the board and administered by the pool
24 administrator. The pool administrator shall offer to administer the
25 questionnaire to each person no longer eligible for coverage under
26 subsection (1)(a)(iii) of this section within thirty days of
27 determining that he or she is no longer eligible;
28 (b) Losing eligibility for pool coverage under this subsection (3)
29 does not affect a person's eligibility for pool coverage under
30 subsection (1)(a)(i), (ii), or (iv) of this section; and
31 (c) The pool administrator shall provide written notice to any
32 person who is no longer eligible for coverage under a pool plan under
33 this subsection (3) within thirty days of the administrator's
34 determination that the person is no longer eligible. The notice shall:
35 (i) Indicate that coverage under the plan will cease ninety days from
36 the date that the notice is dated; (ii) describe any other coverage
37 options, either in or outside of the pool, available to the person;
38 (iii) describe the procedures for the administration of the standard

1 health questionnaire to determine the person's continued eligibility
2 for coverage under subsection (1)(a)(ii) of this section; and (iv)
3 describe the enrollment process for the available options outside of
4 the pool.

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

11 **Sec. 6.** RCW 48.41.110 and 2007 c 259 s 26 and 2007 c 8 s 5 are
12 each reenacted and amended to read as follows:

13 (1) The pool shall offer one or more care management plans of
14 coverage. Such plans may, but are not required to, include point of
15 service features that permit participants to receive in-network
16 benefits or out-of-network benefits subject to differential cost
17 shares. The pool may incorporate managed care features into existing
18 plans.

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

23 (3) The health insurance policies issued by the pool shall pay only
24 reasonable amounts for medically necessary eligible health care
25 services rendered or furnished for the diagnosis or treatment of
26 covered illnesses, injuries, and conditions. Eligible expenses are the
27 reasonable amounts for the health care services and items for which
28 benefits are extended under a pool policy.

29 (4) The pool shall offer at least two policies, one of which will
30 be a comprehensive policy that must comply with RCW 48.41.120 and must
31 at a minimum include the following services or related items:

32 (a) Hospital services, including charges for the most common
33 semiprivate room, for the most common private room if semiprivate rooms
34 do not exist in the health care facility, or for the private room if
35 medically necessary, including no less than a total of one hundred
36 eighty inpatient days in a calendar year, and no less than thirty days

inpatient care for alcohol, drug, or chemical dependency or abuse per calendar year;

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

(c) No less than twenty outpatient professional visits for the diagnosis or treatment of alcohol, drug, or chemical dependency or abuse rendered during a calendar year by a state-certified chemical dependency program approved under chapter 70.96A RCW, or by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

(d) Drugs and contraceptive devices requiring a prescription;

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

(f) Services of a home health agency;

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

(h) Oxygen;

(i) Anesthesia services;

(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)(a) 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.

(b) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen.

(8)(a) Except as provided in (b) 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

1 separated by more than sixty-three days toward the waiting period of
2 the new health plan. For the person previously enrolled in an
3 individual health benefit plan other than a catastrophic health plan,
4 the pool must credit the period of coverage the person was continuously
5 covered under the immediately preceding health plan toward the waiting
6 period of the new health plan. For the purposes of this subsection, a
7 preceding health plan includes an employer-provided self-funded health
8 plan.
9 (b) The pool shall waive any preexisting condition waiting period
10 for a person who is an eligible individual as defined in section
11 2741(b) of the federal health insurance portability and accountability
12 act of 1996 (42 U.S.C. 300gg-41(b)).
13 (9) If an application is made for the pool policy as a result of
14 rejection by a carrier, then the date of application to the carrier,
15 rather than to the pool, should govern for purposes of determining
16 preexisting condition credit.
17 (10) The pool shall contract with organizations that provide care
18 management that has been demonstrated to be effective and shall
19 encourage enrollees who are eligible for care management services to
20 participate. The pool may encourage the use of shared decision making
21 and certified decision aids for preference-sensitive care areas.

22 NEW SECTION. **Sec. 7.** Sections 5 and 6 of this act are necessary
23 for the immediate preservation of the public peace, health, or safety,
24 or support of the state government and its existing public
25 institutions, and take effect immediately.

Passed by the Senate April 18, 2011.
Passed by the House April 7, 2011.
Approved by the Governor May 11, 2011.
Filed in Office of Secretary of State May 11, 2011.