RCW 41.05.400 Plan of health care coverage—Available funds—Components—Eligibility—Director's duties. (1) The director shall design and offer a plan of health care coverage as described in subsection (2) of this section, for any person eligible under subsection (3) of this section. The health care coverage shall be designed and offered only to the extent that state funds are specifically appropriated for this purpose.

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

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

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

(c) Deductibles of three thousand dollars on a per person per calendar year basis, and four thousand dollars on a per family per calendar year basis. The deductible shall be applied to the first three thousand dollars, or four thousand dollars, of eligible expenses incurred by the covered person or family, respectively, except that the deductible shall not be applied to clinical preventive services as recommended by the United States public health service. Enrollee out-of-pocket expenses required to be paid under the plan for cost-sharing and deductibles shall not exceed five thousand dollars per person, or six thousand dollars per family;

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

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

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

(4) The director may not reject an individual for 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 nine-month benefit waiting period for preexisting conditions for which medical advice was given, or 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. Credit against the waiting period shall be provided pursuant to subsections (5) and (6) of this section.

(5) Except for persons to whom subsection (6) of this section applies, the director shall credit any preexisting condition waiting period in the plan for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the plan in a group health benefit plan or an individual health benefit plan other than a catastrophic health plan. The director must credit the period of coverage the person was

continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

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

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

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

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

(b) The director shall provide written notice to any person who is no longer eligible for coverage under the plan within thirty days of the director's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options available to the person; and (iii) describe the enrollment process for the available options. [2023 c 51 § 18; 2000 c 80 § 7; 2000 c 79 § 46.]

Effective date—Severability—2000 c 79: See notes following RCW 48.04.010.