HOUSE BILL REPORT
HB 2523

As Passed House:
February 10, 2012

Title: An act relating to insurers and insurance products.

Brief Description: Regulating insurers and insurance products.

Sponsors: Representatives Bailey, Cody and Kirby; by request of Insurance Commissioner.

Brief History:
Committee Activity:
Business & Financial Services: 1/20/12, 1/24/12 [DP].
Floor Activity:
Passed House: 2/10/12, 96-0.

Brief Summary of Bill

- Makes a number of changes related to health insurance portability.
- Makes a number of changes related to internal and external review processes.
- Prohibits a waiting period for outpatient prescription drugs for enrollees in the Washington State Health Insurance Pool.
- Changes a solvency trigger for Insurance Commissioner action for health insurers and life insurers.
- Makes a number of changes in other areas of the Insurance Code.

HOUSE COMMITTEE ON BUSINESS & FINANCIAL SERVICES

Majority Report: Do pass. Signed by 13 members: Representatives Kirby, Chair; Kelley, Vice Chair; Bailey, Ranking Minority Member; Buys, Assistant Ranking Minority Member; Blake, Condotta, Hudgins, Hurst, Parker, Pedersen, Rivers, Ryu and Stanford.

Staff: Jon Hedegard (786-7127).

Background:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

In 2010 Congress passed, and the President signed, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA). Many of the PPACA's provisions do not go into effect until 2014. However, several health insurance-related provisions, and the administrative rules implementing them, have already gone into effect or will go into effect in the near future. These provisions include:

- minimum medical loss ratios;
- the removal of preexisting condition exclusions for children under age 19;
- the removal of lifetime maximums;
- internal and external review processes;
- mandatory coverage for emergency services;
- dependent coverage until age 26; and
- mandated coverage for preventive services.

Preexisting Condition Exclusions for Health Insurance and Portability.

Preexisting Condition Exclusions Under Federal Law.

The PPACA currently prohibits health insurers from imposing preexisting condition exclusions on persons under age 19. Beginning in 2014, this prohibition will apply to all consumers.

Preexisting Condition Exclusions Under State Law.

Generally, health insurers who offer conversion contracts or policies, i.e., a contract or policy that converts group coverage to individual coverage, may not exclude preexisting conditions. However, a preexisting condition exclusion is allowed to the extent that any waiting period in the original group coverage for a preexisting condition has not been satisfied. In 2011 a state law was enacted that made a number of changes related to implementation of the PPACA. The 2011 act intended to make the PPACA implementation changes provided that conversion contracts and conversion policies may not contain exclusions for preexisting conditions for any applicant who is under age 19.

Health Insurance Portability Under State Law.

A person seeking to purchase an individual health plan or enroll in the Basic Health Plan administered by the Health Care Authority (HCA) may have to complete a standard health questionnaire. The results of the questionnaire may qualify the person for coverage by the Washington State Health Insurance Pool (WSHIP). If the person qualifies for the WSHIP, a health carrier may decide to not enroll the person in an individual health plan and the HCA shall not enroll the person in the Basic Health Plan.

Internal and External Review Procedures for Health Insurance.

Internal and External Review Procedures Under Federal Law.

1. Internal Review.

Under the PPACA, health insurers must have an effective internal appeals process for appeals of coverage determinations and claims. Enrollees must be informed of the appeals process in a culturally and linguistically appropriate manner. Enrollees must also be informed of any applicable office of health insurance consumer assistance or ombudsman established under the federal Public Health Service Act.

Notice of an adverse benefit determination must contain the following information:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and
- the reason or reasons for the adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

2. External Review.
The PPACA also requires health insurers to comply with applicable state external review processes that contain at least the protections in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC). Additionally, the federal rules adopted to implement the PPACA require the external review process to meet the following criteria:

- The independent review organization (IRO) involved in the review may not have any conflicts of interest.
- Claimants must be provided with at least five business days to submit additional information to the IRO, which the IRO must forward to the carrier within one business day.
- The IRO must provide notice of its decision within 45 days of the request for external review.
- An expedited review process must be available for determinations regarding admissions, availability of care, continued stay, health care services for which the claimant received emergency services but has not been discharged, or medical conditions for which a 45-day wait would jeopardize the life, health, or function of the claimant. The IRO must provide notice of its decision within 72 hours. If the notice is not in writing, the notice must be followed by written confirmation within 48 hours.
- With respect to claims involving experimental or investigational treatments, the IRO must provide protections to ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.
- The IRO must maintain written records that are available to the state.

Internal and External Review Procedures Under State Law.
1. Internal Review.
In 2011 a state law was enacted that made a number of changes related to PPACA implementation and to conform the existing state internal review process to the PPACA standards. Every health insurer must have a fully operational, comprehensive grievance process. An insurer must respond to an enrollee's dissatisfaction about customer service or health service availability in a timely and thorough manner. Enrollees must be provided with written notice of decisions to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits. Appeals of adverse decisions must be processed within 30 days (or 72 hours if the 30-day timeline could seriously jeopardize the enrollee's life, health, or function). An insurer must make its grievance process accessible to enrollees who are limited English speakers, have disabilities, or have physical or mental disabilities. When adopting rules on internal grievance processes, the Insurance Commissioner (Commissioner) must consider grievance processes as approved by

the federal Department of Health and Human Services or the federal Department of Labor (unless the health plans are grandfathered). The state Department of Health (DOH) oversees the IRO process and the state requirements for the IRO process are largely found in the DOH's laws or rules.

2. External Review.
In 2011 a state law was enacted that made a number of changes related to PPACA implementation and to conform the existing state IRO process to the PPACA standards. Once a health insurer's grievance process has been exhausted, the enrollee may seek review by an IRO. The Office of the Insurance Commissioner (OIC) maintains a rotational registry for the assignment of an IRO to each dispute. The IRO may override the insurer's medical necessity or appropriateness standards if the standards are unreasonable or inconsistent with sound, evidence-based medical practice. An IRO involved in a review may not have any conflicts of interest. Enrollees must be provided with at least five business days to submit additional information to the IRO, which the IRO must forward to the carrier within one business day. An expedited review process must be available for determinations regarding admissions, availability of care, continued stay, health care services for which the claimant received emergency services, but has not been discharged, or medical conditions for which a 45-day wait would jeopardize the life, health, or function of the claimant. The IRO must provide notice of its decision within 72 hours. If the notice is not in writing, the notice must be followed by written confirmation within 48 hours. With respect to claims involving experimental or investigational treatments, the IRO must provide protections to ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process. The IRO must maintain written records that are available to the state. The Commissioner must consider standards adopted by the NAIC when promulgating rules regarding IROs.

Dependent Coverage to Age 26.
Dependent Coverage Under Federal Law.
Under the PPACA, if a health insurer offers dependent coverage, a child may stay on the parent's plan until age 26, unless the child's employer offers health insurance.

Dependent Coverage Under State Law.
In 2011 a state law was enacted that made a number of changes related to PPACA implementation. The 2011 act provided that health insurers who offer dependent coverage must offer the option of covering any dependent under age 26. Health insurers in the WSHIP must terminate dependent coverage at age 26.

The Washington State Health Insurance Pool.
The WSHIP is the "high-risk" health insurance pool for this state. The WSHIP offers health insurance to residents of this state who are rejected for coverage in the individual market due to medical reasons. Enrollees into the WSHIP may face a benefit waiting period for preexisting conditions. The benefit waiting period may not be applied to prenatal care services.

Risk-Based Capital Reports.
All insurers must file reports that use formulas to assess their solvency and the nature of the risk of their business. If the reports do not meet a specific threshold, a correlative action may

be taken by the Commissioner. The steps are progressive and range from additional reports to a takeover of a company. The first step is called a "company action level event" where the insurer must submit a report that identifies what led to the situation, corrective action to remedy the situation, and a projection of financial results with and without the corrective actions. Life insurers and health insurers may face an action level event if their Risk-Based Capital (RBC) result does not exceed 2.5 times the "authorized control level" and has a negative trend.

Multiple Employer Welfare Arrangements.
A multiple employer welfare arrangement (MEWA) is a group purchasing arrangement defined by the federal Employee Retirement Income Security Act of 1974 (ERISA). The ERISA defines a MEWA as an employee welfare benefit plan or other arrangement established or maintained to offer or provide welfare plan benefits to employees of two or more employers or their beneficiaries. An employee welfare benefit plan is defined to include medical, surgical, or hospital care or benefits as well as sickness, accident, disability, and death benefits. The ERISA generally preempts state laws relating to employee benefit plans. An exception allows the application of state insurance laws to ERISA-covered welfare plans that meet the MEWA definition. The state applies a regulatory structure to MEWAs. One part of that structure requires any person who exercises control over the financial dealings and operations of the MEWA to be fingerprinted as a part of a background check by the Washington State Patrol (WSP) and the Federal Bureau of Investigation (FBI).

Adjusters.
An adjuster is a person who is compensated for investigating or reporting on claims arising under insurance contracts on the sole behalf of either the insurer or the insured.

A person may not hold themselves out to be an adjuster unless licensed by the OIC or otherwise authorized under law to act as an adjuster. Adjusters have to undergo background checks in the licensing process. In 2010 a law was an enacted that allowed non-resident adjusters who are licensed in another state to receive reciprocity in this state. Over the last several years, numerous laws have been enacted addressing insurance producers, including changes regarding reciprocity and also designation of a home state. "Home state" is defined as "the District of Columbia and any state or territory of the United States or province of Canada in which an insurance producer maintains the insurance producer's principal place of residence or principal place of business, and is licensed to act as an insurance producer."

Solicitation Permits for Domestic Insurers.
A domestic insurer is an insurer organized under Washington law. A person forming or seeking to form an insurer in this state may not advertise, or solicit or receive any funds, agreement, stock subscription, or membership unless the person has a solicitation permit from the OIC. A person applying for a solicitation permit must provide the contact information and fingerprints of every person that will be associated with the formation of the insurer for a state and national criminal background check. The background check will be performed by the WSP and the FBI and possibly other governmental agencies.

Charitable Gift Annuities.
Charitable gift annuity (CGA) businesses are regulated under the Insurance Code. The Commissioner may grant a certificate of exemption to any insurer or educational, religious,

charitable, or scientific institution conducting a charitable gift annuity business that meets specific criteria. The Commissioner may refuse to grant, revoke, or suspend a certificate of exemption if the Commissioner finds the CGA does not meet statutory requirements, has not acted in good faith, or has violated an unfair practice law.

Service of Process.
Service of process is the legal procedure of notifying an affected person or business of a pending legal action. The Insurance Code contains provisions that require a wide variety of nonresident persons and businesses to follow certain procedures in appointing the Commissioner their attorney for the purpose of receiving service of process. Generally, the person or entity must provide the Commissioner with the name, title, and address of the person who should be contacted about the action. Service of process provisions were changed for OIC licensees in 2010 and 2011.

Casualty Rate Credits.
As a general rule, casualty rates must be filed with and approved by the Commissioner. The standard for rate review is that premium rates for insurance shall not be excessive, inadequate, or unfairly discriminatory. In 1986 an omnibus act was enacted that made a number of changes throughout the tort system. One part of that law required the Commissioner to review casualty rate filings to determine if a credit to casualty policyholders was required based on the changes in the 1986 act.

The Centers for Medicare and Medicaid Services.
The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services. The CMS administers the Medicare program, works with state governments to administer Medicaid and the State Children's Health Insurance Program, and oversees certain health insurance portability standards. The CMS was known as the Health Care Financing Administration from 1977-2001.

Summary of Bill:

Preexisting Condition Exclusions for Health Insurance and Portability.
Persons under age 19 are exempt from having to complete the standard health questionnaire if they are in the individual market because their employer has discontinued coverage. A person seeking enrollment into the Basic Health Plan as a nonsubsidized enrollee is exempt from the standard health questionnaire if the person meets certain continuous coverage standards.

Internal and External Review Procedures for Health Insurance.
A definition of "grievance" that applies to all health carriers is modified to eliminate a complaint about a denial or payment or non-provision of medical services. The definition of "meaningful grievance procedure" in the definitions applying to health maintenance organizations (HMOs) is modified to become "meaningful appeal procedure" and "meaningful adverse determination review" procedure. Each carrier and health plan must have a comprehensive grievance and appeal process. A reference to a time frame of 45 days for the expedited review process is removed. Plans that are not grandfathered must have fully operational, comprehensive, and effective grievance and review of adverse benefit

determination processes. With coverage offered under a group health plan, if either the carrier or the health plan complies with the section, then the obligation to comply is satisfied for both the carrier and the plan. Health plans, in addition to carriers, must provide written notices of a decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health services or benefits (denial). A person may request a reconsideration of a denial. If the request is made under a grandfathered plan, the carrier and the plan must process it as an appeal. If it is made under a plan that is not grandfathered, the plan and carrier must process it as a review of an adverse benefit determination. Similar distinctions are made between grandfather plans and plans that are not grandfathered with regard to an enrollee's rights, continuation of coverage, explanations of the processes, accessibility to enrollees who are limited English speakers, have disabilities, or have physical or mental disabilities, tracking of appeals, and record-keeping. Several references to grievances in provisions that apply only to HMOs are struck and replaced by a meaningful appeal procedure. A requirement that a detailed description of a carrier's grievance system must be provided to the OIC is deleted. The Commissioner will no longer consider a HMO's agreements with providers for the provision of health care services or procedures to resolve grievances as a part of the HMO's registration process.

Dependent Coverage to Age 26.
Language regarding coverage for dependent children under age 26 is modified for insurance offered by health care service contractors, HMOs, and disability insurers. The requirement that individual plans offer the option of covering a dependent child under age 26 is changed by removing "dependent" and limiting the broad requirement to plans that are not "grandfathered plans" as defined in existing law. Grandfathered plans must offer the option of coverage until age 26 unless the child is eligible to enroll in an eligible health plan sponsored by the child's employer or the child's spouse's employer.

The Washington State Health Insurance Pool.
The WSHIP may not apply a benefit waiting period to benefits for outpatient prescription drugs.

Risk-Based Capital Reports.
Health carriers and life insurers may face an action level event if their RBC result does not exceed three times the authorized control level.

Multiple Employer Welfare Arrangements.
The background check must be performed by a vendor authorized by the NAIC to perform state, national, and international background checks.

Adjusters.
The definition of "home state" is modified to include adjusters, in addition to insurance producers. Nonresident applicants for an adjuster license must provide background information if they designate Washington as their home state. A nonresident adjuster applicant who does not designate Washington as a home state does not need to meet fingerprint requirements. A nonresident adjuster applicant state must meet the resident adjuster standards of the applicant's designated home state. If a nonresident adjuster applicant resides or has their principal place of business in another state that does not have substantially similar laws regarding adjuster licensure and the applicant is licensed and acts

as an adjuster in this state or a third state, the applicant may list this state or the third state as their designated home state.

Solicitation Permits for Domestic Insurers.
Provisions regarding the background checks are changed. A person applying for a solicitation permit must provide biographical reports for every person that will be an officer, director, trustee, employee, or fiduciary of the insurer. The background check must be performed by a vendor authorized by the NAIC to perform state, national, and international background checks.

Charitable Gift Annuities.
A provision is removed that requires the Commissioner to revoke a certification of exemption if the CGA fails to establish and maintain a separate reserve fund. The Commissioner may also refuse to grant, revoke, or suspend a certificate of exemption if the Commissioner finds the CGA has violated additional provisions of law specific to the CGAs or has violated a rule applicable to the CGAs.

Service of Process.
A reference to unauthorized foreign or alien insurers is changed to authorized foreign or alien insurers.

Casualty Rate Credits.
The provision regarding the review and credit is repealed.

The Centers for Medicare and Medicaid Services.
References to the Health Care Financing Administration are changed to the Centers for Medicare and Medicaid Services.

Other grammatical and clarifying changes are made, including changes to incorrect cites.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The bill includes quite a bit of health care changes. It also has some property and casualty changes. The bill is cosponsored by the chair of the Health Care and Wellness Committee. The bill was developed with the stakeholders with the idea that there will be no unfriendly amendments. If there are issues with any provisions in the bill, those sections will be removed from the bill. The Insurance Commissioner considered running two separate bills; one regarding health care and the other bill covering everything else. Last year, a health care clean-up bill was threatened with hostile amendments. It was decided that one bill was a better method. A summary of the changes were provided to the chair and staff of the Health Care and Wellness Committee.

(Opposed) None.

Persons Testifying: Representative Kirby, prime sponsor; Drew Bouton, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying: None.