SENATE BILL REPORT
SB 5122

As of January 26, 2011

Title: An act relating to health care insurance.

Brief Description: Regulating health care insurance.

Sponsors: Senators Keiser and Kline; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long-Term Care: 1/26/11.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: The federal Patient Protection and Affordability Care Act (PPACA), passed in March 2010, includes a number of provisions that impact medical insurance plans or insurance carriers. A number of provisions have early implementation dates, some are effective for policies issued on or after September 23, 2010.

The state insurance statutes codified in Title 48 RCW, which apply to regulated insurance carriers, need modification to reflect the federal requirements that are in place now. The early implementation insurance changes include extending coverage to dependents to age 26 for all plans that offer dependent coverage; elimination of lifetime benefit maximums; prohibition of rescission of coverage; elimination of pre-existing condition waiting period for persons under 19; coverage changes for emergency services; enhanced consumer information including appeals requirements; and reporting of medical loss ratios (the percent of premium spent on medical expenses) with a requirement for rebates to enrollees triggered by certain medical loss ratios.

Summary of Bill: The state insurance statutes are modified to reflect the PPACA insurance provisions with early implementation. Coverage for dependents is extended to age 26. Lifetime benefit maximums are removed. Policies for persons under 19 may not include pre-existing condition exclusions.

Federal definitions are inserted for adverse benefit determination; emergency services; final external review decision; and final internal adverse benefit determination.

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.

Federal standards for emergency services are inserted to require coverage of emergency services with the same copayments or coinsurance for in-network and out-of-network emergency services, and to allow services without prior authorization. Patients may be balance billed for emergency services provided by an out-of-network provider. Charges may be (1) the balance of what the out-of-network provider charges relative to the carrier's in-network provider rate (or rates) for emergency services, excluding in-network copayments or coinsurance; (2) the balance using the usual, customary, and reasonable billing amount, excluding any in-network copayment or coinsurance; or (3) the balance using the amount Medicare would pay for the emergency services, excluding the in-network copayment or coinsurance. Other cost-sharing, such as a deductible or out-of-pocket maximum, may be imposed for emergency services provided out-of-network only if the cost-sharing generally applies to all out-of-network benefits.

The grievance process is modified to reflect new federal requirements, including approval by the Department of Health and Human Services or the Department of Labor for each carrier's process. Written notices of any decision to deny benefits or terminate coverage must include additional information, including the claim involved, the date of service, the provider, the amount, the diagnosis code and meaning, the treatment code and meaning, the reason for the adverse benefit determination or denial, and a description of the plan's standard for decision making. The information provided to the enrollee must include contact information for the consumer assistance or ombudsman who can assist with the claims appeal and external review processes.

Independent reviews of appeals must be completed by an organization that does not have a conflict of interest. Claimants must have at least five business days to submit additional information to the independent review organization. The independent review organization must forward any additional information within one business day. A benefit decision must be provided within 45 days of the request for external review. Expedited review must be completed within 72 hours.

The rate information for individual health benefit plans is modified to remove the calculation of the remittance to the high risk pool that is based on the declination rate (rate of declining applicants due to health screening), to ensure health insurance carriers do not pay the current remittance and the new federal rebate to enrollees that is triggered if the individual plan's medial loss ratio is less than 80 percent. The remittance calculation is removed effective January 1, 2012.

Appropriation: None.

Fiscal Note: Not requested.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This reflects changes in federal law and we are continuing to work with carriers and others on potential refinements to the language.

CON: We are opposed to the changes in emergency services. We believe our current state law provides greater protection than the federal language and we should retain the current state language.

Persons Testifying: PRO: Drew Bouton, Office of Insurance Commissioner.

CON: Tim Layton, Washington State Medical Association.