FINAL BILL REPORT
ESSB 5122

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Synopsis as Enacted

Brief Description: Making the necessary changes for implementation of the affordable care act in Washington state.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Keiser and Kline; by request of Insurance Commissioner).

Senate Committee on Health & Long-Term Care
House Committee on Health Care & Wellness

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: 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, final external review decision, and final internal adverse benefit determination and grandfathered health plan.

The grievance process required for each plan may reflect differences for grandfathered health plans and approval of HHS.

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.

Independent reviews of appeals must be completed by an organization that does not have a conflict of interest. Enrollees 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.

Changes are made for the Washington State Health Insurance Pool (WSHIP), removing the lifetime maximum on benefits of $2 million, extending dependents eligibility to age 26, and allowing the pool to waive the recertification of the standard health questionnaire and the rebidding of the pool if the program is discontinued during the 36-month review cycle.

Health care sharing ministries are not health carriers or insurers under our state insurance laws, and must follow the definition of health care sharing ministries provided in federal law in the Internal Revenue Code (26 USC Sec 5000A).

Votes on Final Passage:

Senate	45	4	
House	63	32	(House amended)
Senate	44	2	(Senate concurred)

Effective: July 22, 2011.