SENATE BILL REPORT
SB 6181

As of January 23, 2012

Title: An act relating to insurers and insurance products.

Brief Description: Regulating insurers and insurance products.

Sponsors: Senators Keiser, Benton and Hobbs; by request of Insurance Commissioner.

Brief History:
Committee Activity: Financial Institutions, Housing & Insurance: 1/24/12.

SENATE COMMITTEE ON FINANCIAL INSTITUTIONS, HOUSING & INSURANCE

Staff: Edward Redmond (786-7471)

Background: The federal Patient Protection and Affordability Care Act (ACA), passed in March 2010, includes a number of provisions that impact medical insurance plans or insurance carriers. These provisions include:

- minimum medical loss ratios;
- the removal of pre-existing condition exclusions for children under the age of 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.

Many of these provisions do not go into effect until 2014; however, some provisions have already taken effect or will go into effect in the near future.

In 2011 the Legislature modified the state's insurance statutes to parallel the federal requirements that are currently in place. These modifications included:

- extending coverage for dependents to age 26 for all plans that offer dependent coverage;
- eliminating lifetime benefit maximums;
- prohibiting rescission of coverage;
- eliminating the waiting period for pre-existing conditions for persons under age 19;
- coverage changes for emergency services;
- enhanced consumer information including appeals requirements; and

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- 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 further modified as follows to come into conformity with the ACA insurance provisions:
Preexisting Condition Exclusions for Health Insurance and Portability. Persons under the age 19 are exempt from having to take 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 timeframe 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 recordkeeping. Several references to grievances in provisions that apply only to HMOs are struck and replaced by meaningful appeal procedure. A requirement that a detailed description of a carrier's grievance system must be provided to the Office of Insurance Commissioner (Commissioner) is deleted. The Commissioner no longer considers an 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 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 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 (WSHIP). The WSHIP may not apply a benefit waiting period to benefits for outpatient prescription drugs.

Risk-Based Capital Reports (RBC). 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 National Association of Insurance Commissioners (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 is 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 (CGA). 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 & Medicaid Services. References to the Health Care Financing Administration are changed to the Centers for Medicare & Medicaid Services.

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

Appropriation: None.

Fiscal Note: Requested on January 21, 2012.

Committee/Commission/Task Force Created: No.

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