SHB 1846 - H AMD **277**
By Representative Schmick

WITHDRAWN 03/11/2013

Strike everything after the enacting clause and insert the following:

"**Sec. 1.** RCW 48.43.715 and 2012 c 87 s 13 are each amended to read as follows:

(1) Consistent with federal law, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the minimum requirements of section 1302.

(3) A health plan required to offer the essential health benefits, other than a health plan offered through the federal basic health program or medicaid, under P.L. 111-148 of 2010, as amended, may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner ((~~must~~)):

(a) Must ensure that the plan covers the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended; and

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended.

(4) A stand-alone dental plan may be offered off the exchange in the individual and small group market if the commissioner finds that it meets the requirements of this subsection. For purposes of this subsection, "stand-alone dental plan" means a health plan that only covers the essential health benefits category of pediatric oral services to persons under the age of nineteen. A stand-alone dental plan is a health plan as defined in RCW 48.43.005, and is not a dental only plan for the purposes of RCW 48.43.005(26)(k).

(a) The commissioner shall establish by rule the review and approval requirements and procedures for plan coverage and rating for stand-alone dental plans. The rules must:

(i) Include a requirement that issuers submit data that is necessary for the commissioner to evaluate purchasing patterns and coverage duration for pediatric dental services purchased off the exchange; and

(ii) Be consistent with federal law.

(b) If a plan is certified by the exchange as a stand-alone dental plan, it is deemed approved for offer in the nongrandfathered individual and small group market off the exchange.

(c) The commissioner shall permit issuers to also include the essential health benefit category of pediatric oral services in a nongrandfathered individual and small group health benefit plan that covers the remaining essential health benefits benchmark package and that is offered off the exchange.

(5) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs.

Sec. 2. RCW 48.46.243 and 2008 c 217 s 56 are each amended to read as follows:

(1) Subject to subsection (2) of this section, every contract between a health maintenance organization and its participating providers of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the agreement, the enrolled participant shall not be liable to the provider for any sums owed by the health maintenance organization. Every such contract shall provide that this requirement shall survive termination of the contract.

(2) The provisions of subsection (1) of this section shall not apply:

(a) To emergency care from a provider who is not a participating provider((,));

(b) To out-of-area services;

(c) To the delivery of covered pediatric oral services that are substantially equal to the essential health benefits benchmark plan; or((,))

(d) In exceptional situations approved in advance by the commissioner, if the health maintenance organization is unable to negotiate reasonable and cost-effective participating provider contracts.

(3)(a) Each participating provider contract form shall be filed with the commissioner fifteen days before it is used.

(b) Any contract form not affirmatively disapproved within fifteen days of filing shall be deemed approved, except that the commissioner may extend the approval period an additional fifteen days upon giving notice before the expiration of the initial fifteen-day period. The commissioner may approve such a contract form for immediate use at any time. Approval may be subsequently withdrawn for cause.

(c) Subject to the right of the health maintenance organization to demand and receive a hearing under chapters 48.04 and 34.05 RCW, the commissioner may disapprove such a contract form if it is in any respect in violation of this chapter or if it fails to conform to minimum provisions or standards required by the commissioner by rule under chapter 34.05 RCW.

1 (4) No participating provider, or insurance producer, trustee, or
2 assignee thereof, may maintain an action against an enrolled
3 participant to collect sums owed by the health maintenance
4 organization."

5 Correct the title.

EFFECT: Defines "stand-alone dental plan" as a health plan that only covers the essential health benefits category of pediatric oral services to persons under the age of 19. Clarifies that a stand-alone dental plan is not a "dental only" plan (under current law, "dental only" plans are exempt from certain insurance regulations). Requires the Insurance Commissioner's rules on stand-alone dental plans to include procedures for plan coverage and rating and a requirement that issuers submit data necessary for the Insurance Commissioner to evaluate purchasing patterns and coverage duration for pediatric dental services purchased off the exchange. Requires the Insurance Commissioner to deem as approved stand-alone dental plans that have been certified by the exchange. Requires the Insurance Commissioner to allow carriers to include the essential health benefit of pediatric oral services in off-exchange individual and small group plans that cover the remaining essential health benefits benchmark package. Allows a health maintenance organization to provide coverage for pediatric oral services that are substantially equal to the essential health benefits benchmark plan using noncontracted providers.

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