HOUSE BILL REPORT
SHB 1638

As Passed House:
March 8, 2013

Title: An act relating to insurance.

Brief Description: Addressing insurance, generally.

Sponsors: House Committee on Business & Financial Services (originally sponsored by Representatives Ryu, Kirby, Cody and Morrell; by request of Insurance Commissioner).

Brief History:
Committee Activity:
Business & Financial Services: 2/13/13, 2/19/13 [DPS].
Floor Activity:
Passed House: 3/8/13, 72-26.

Brief Summary of Substitute Bill

- Makes a number of changes applying to insurers providing health coverage, including: the types of plans that may be offered, rate information that must be filed, and dependent coverage.
- Requires health maintenance organizations to file provider contracts with the Insurance Commissioner (Commissioner).
- Allows the Commissioner to reimburse the expenses of volunteers.
- Modifies the Commissioner's duties regarding medical malpractice closed claim reports.
- Makes a number of technical changes and language changes.

HOUSE COMMITTEE ON BUSINESS & FINANCIAL SERVICES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 14 members: Representatives Kirby, Chair; Ryu, Vice Chair; Parker, Ranking Minority Member; Vick, Assistant Ranking Minority Member; Blake, Chandler, Habib, Hawkins, Hudgins, Hurst, Kochmar, O'Ban, Santos and Stanford.

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.

Minority Report: Do not pass. Signed by 1 member: Representative MacEwen.

Staff: Jon Hedegard (786-7127).

Background:

The Office of the Insurance Commissioner was created by the Legislature in the 1889-90 session. It became a separately elected statewide office in 1907. Under the Insurance Code, the Insurance Commissioner (Commissioner) may adopt rules, hold hearings, and investigate and examine persons and entities regarding potential violations of the laws of Washington. The Commissioner can issue, deny, suspend, and revoke licenses, issue cease and desist orders, and levy fines of up to $1,000 per violation of the code.

Patient Protection and Affordable Care Act.
Health Benefit Exchanges.
The Federal Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (ACA) requires every state to establish two Health Benefit Exchanges, one for small businesses and one for individuals. The exchanges may be administratively operated as one entity (Exchange). If a state elects not to establish an Exchange, the federal government will operate one either directly or through an agreement with a nonprofit entity. The Exchange's functions must include:

- facilitating the purchase of qualified health plans by individuals and small groups;
- certifying health plans as qualified health plans based on federal guidelines;
- providing information to individuals about their eligibility for public programs like Medicaid and the Children's Health Insurance Program and enrolling eligible individuals in those programs;
- operating a telephone hotline and website to assist consumers in the Exchange; and
- establishing navigator programs to help inform consumers and facilitate their enrollment in qualified health plans in the Exchange.

The Exchange is to begin operations by January 1, 2014, consistent with federal law and statutory authorization. The Exchange is governed by a nine-member board (Board) appointed by the Governor from a list submitted by all four caucuses of the House of Representatives and the Senate. The Exchange is authorized to serve as a premium aggregator and to complete other duties necessary to begin open enrollment beginning October 2, 2013. The Board must establish rules or policies permitting entities to pay premiums on behalf of qualified individuals. The Exchange is required to be self-sustaining, which is defined as capable of operating without direct state tax subsidy. If at any time the Exchange is no longer self-sustaining, its operations must be suspended. The Board must develop funding mechanisms that fairly and equitably apportion among carriers the administrative costs and expenses of the Exchange and must develop a methodology to ensure that the Exchange is self-sustaining.

Market Rules.
The ACA specifies four categories of plans to be offered through the Exchange and in the individual and small group markets. The categories are based on the actuarial value of the plans; i.e., the percentage of the costs the plan is expected to pay:

- Platinum: 90 percent actuarial value;

- Gold: 80 percent actuarial value;
- Silver: 70 percent actuarial value; and
- Bronze: 60 percent actuarial value.

The following market rules apply to health plans:

- for plan or policy years beginning January 1, 2014, if a carrier offers a Bronze plan outside the Exchange, it must also offer Gold and Silver plans outside the Exchange; and
- catastrophic plans (as defined in the ACA) may only be sold inside the Exchange.

All health plans outside of the Exchange, other than catastrophic plans, must offer plans that conform to the Platinum, Gold, Silver, and Bronze value tiers specified in the ACA.

Qualified Health Plans.
Only qualified health plans may sell insurance in the Exchange. In order to be a qualified health plan, a carrier must, at a minimum:

- be certified as a qualified health plan based on federal guidelines;
- provide coverage for the essential health benefits;
- offer at least one Silver and one Gold plan in the Exchange; and
- charge the same premium, both inside and outside the Exchange.

The Board must certify a health plan as a qualified health plan if the plan:

- is determined by the Commissioner as meeting state insurance laws and regulations;
- is determined by the Board to meet the requirements of the ACA; and
- is determined by the Board to include tribal clinics and urban Indian clinics as essential community providers in the plan's provider network consistent with federal law. An integrated delivery system may be exempt from the essential community provider requirement if consistent with federal law.

A decision by the Board denying a request to certify or recertify a plan as a qualified health plan may be appealed according to procedures adopted by the Board.

Health Carrier Rate Filing.
A health carrier must submit certain rate information in connection with small group or individual health benefit rate filings to the Commissioner. The information is specified by the United States Department of Health and Human Services (HHS).

Grandfathered Plans.
Under the ACA and state law, certain group health plans or an individual health plan are "grandfathered" and do not have to meet all of the requirements of the ACA.

Dependent Coverage.
Any individual disability insurance contract that is not grandfathered and provides coverage for a participating member's dependent must offer each participating member the option of covering any dependent under the age of 26.

Any group disability insurance contract or blanket disability insurance contract that provides coverage for a participating member's dependent must offer each participating member the option of covering any dependent under the age of 26.

Health Maintenance Organizations (HMOs).
In order to provide health coverage in Washington, an HMO must have a certificate of registration with the Commissioner. The application requires the provision of certain information. The Commissioner must determine if it is reasonable to expect the HMO to meet its obligations to its enrolled policyholders. Until 2012 one of the factors the Commissioner had to consider was any agreements the HMO had with providers for the provision of health services. In 2012 Commissioner-requested legislation removed this factor from consideration.

State Reimbursement.
State employees may be reimbursed for subsistence, lodging, travel, and meals while engaged on official business away from their designated work stations.

Medical Malpractice Closed Claim Reporting.
Self-insurers and insuring entities that write medical malpractice insurance are required to report medical malpractice closed claims that are closed after January 1, 2008, to the Commissioner. Closed claims reports must be filed annually by March 1, and must include data for closed claims for the preceding year. The reports must contain specified data relating to: the type of health care provider, specialty, and facility involved; the reason for the claim and the severity of the injury; the dates when the event occurred, the claim was reported to the insurer, and the suit was filed; the injured person's age and sex; and information about the settlement, judgment, or other disposition of the claim, including an itemization of damages and litigation expenses.

If a claim is not covered by an insuring entity or self-insurer, the provider or facility must report the claim to the Commissioner after a final disposition of the claim. The Commissioner may impose a fine of up to $250 per day against an insuring entity that fails to make the required report. The Department of Health may require a facility or provider to take corrective action to comply with the reporting requirements.

A claimant or the claimant's attorney in a medical malpractice action that results in a final judgment, settlement, or disposition, must report to the Commissioner certain data, including the date and location of the incident, the injured person's age and sex, and information about the amount of judgment or settlement, court costs, attorneys' fees, or expert witness costs incurred in the action.

The Commissioner must use the data to prepare aggregate statistical summaries of closed claims. The Commissioner must also prepare an annual report of closed claims. The annual report must include specified information.

Any information in a closed claim report that may result in the identification of a claimant, provider, health care facility, or self-insurer is exempt from public disclosure.

Summary of Substitute Bill:

Patient Protection and Affordable Care Act.
Market Rules.
For plan or policy years beginning January 1, 2014, a carrier that offers:

- a Bronze level health benefit plan in the individual market outside of the Exchange must also offer Silver and Gold level plans in the individual market outside of the Exchange; and
- a Bronze level health benefit plan in the small group market outside of the Exchange must also offer Silver and Gold level plans in the small group market outside of the Exchange.

The individual and small group health plans outside of the Exchange that must conform to the Platinum, Gold, Silver, and Bronze value tiers specified in the ACA are the plans that are not grandfathered.

Health Carrier Rate Filing.
The information a carrier is required to file with the Commissioner may be revised from time to time by the HHS.

Dependent Coverage.
The provision that an individual disability insurance contract that provides coverage for a participating member's dependent must offer the option of covering any dependent under the age of 26 is limited to health benefit plans that are not grandfathered.

Any group disability insurance contract or blanket disability insurance contract that provides health benefit coverage for a participating member's dependent must offer each participating member the option of covering any dependent under the age of 26.

Health Maintenance Organizations.
Agreements with providers for the provision of health services are one of the factors the Commissioner has to consider when determining if it is reasonable to expect an HMO that is applying for a certificate or registration is able to meet its obligations to its enrolled policyholders.

State Reimbursement.
The Commissioner may authorize reimbursement of:

- authorized volunteer projects, training, and travel in the same manner as for state employees; and
- other reasonable expenses related to volunteer recognition.

Surplus Lines.
When the surplus line policy covers risks or exposures located both inside and outside of the United States and its territories, the tax is computed without regard to the proportion of the premium properly allocable to the risks and exposures located outside of the United States and its territories.

Medical Malpractice Closed Claim Reporting.
The requirement that the Commissioner must prepare aggregate statistical summaries of closed claims is repealed. Provisions related to the Commissioner's annual report of closed

claims are modified, and the due date of the report is changed from June 30 of each year to September 1 of each year.

A number of technical changes and grammatical changes are made.

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 is requested by the Commissioner. The bill makes a number of corrections and changes. The Commissioner worked with all affected stakeholders and those stakeholders support the bill. The health care sections were requested by health carriers and have been reviewed by the Chair of the Health Care and Wellness Committee. The bill makes a wide variety of statutory changes. The changes to surplus line taxation statutes arise from a change in federal law. Federal law addresses how surplus line premiums should be taxed if located inside or outside of the state. The federal law did not address risks located outside of the country. The Commissioner does not want to tax risks that are not taxed today. There is a drafting ambiguity in the section that addresses surplus lines taxation and the Commissioner would prefer to remove that section at this time and approach the issue next year after further work with stakeholders.

(Opposed) None.

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

Persons Signed In To Testify But Not Testifying: None.