H-3326.1

HOUSE BILL 2328

State of Washington 63rd Legislature 2014 Regular Session

By Representatives Cody, Riccelli, and Jinkins

Read first time 01/15/14. Referred to Committee on Health Care & Wellness.

AN ACT Relating to the Washington state health insurance pool; and amending RCW 48.41.080, 48.41.090, 48.41.110, and 48.41.120.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 48.41.080 and 2011 c 314 s 14 are each amended to read as follows:

The board shall select an administrator ((~~through a competitive bidding process~~)) to administer the pool.

(1) The board shall evaluate ((~~bids~~)) administrators based upon criteria established by the board, which shall include:

(a) The administrator's proven ability to handle health coverage;

(b) The efficiency of the administrator's claim-paying procedures;

(c) An estimate of the total charges for administering the plan; and

(d) The administrator's ability to administer the pool in a cost-effective manner.

(2) ((~~The administrator shall serve for a period of three years subject to removal for cause. At least six months prior to the expiration of each three-year period of service by the administrator, the board shall invite all interested parties, including the current~~

~~administrator, to submit bids to serve as the administrator for the succeeding three-year period. Selection of the administrator for this succeeding period shall be made at least three months prior to the end of the current three-year period, unless at the time required for submission of bids pursuant to this subsection to the pool will be discontinued before the end of the succeeding thirty-six month period~~)) The administrator shall serve pursuant to a contract. Upon expiration of the term of the contract, the board may, in its discretion, renew the contract or select an administrator by soliciting bids from qualified contractors.

(3) The administrator shall perform such duties as may be assigned by the board including:

(a) Administering eligibility and administrative claim payment functions relating to the pool;

(b) Establishing a premium billing procedure for collection of premiums from covered persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing;

(c) Performing all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(i) Making available information relating to the proper manner of submitting a claim for benefits to the pool, and distributing forms upon which submission shall be made;

(ii) Taking steps necessary to offer and administer managed care benefit plans; and

(iii) Evaluating the eligibility of each claim for payment by the pool;

(d) Submission of regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board;

(e) Following the close of each accounting year, determination of net paid and earned premiums, the expense of administration, and the paid and incurred losses for the year and reporting this information to the board and the commissioner on a form as prescribed by the commissioner.

(4) The administrator shall be paid as provided in the contract between the board and the administrator for its expenses incurred in the performance of its services.

Sec. 2. RCW 48.41.090 and 2013 2nd sp.s. c 6 s 7 are each amended to read as follows:

(1) Following the close of each accounting year, the pool administrator shall determine the total net cost of pool operation which shall include:

(a) Net premium (premiums less administrative expense allowances), the pool expenses of administration, and incurred losses for the year, taking into account investment income and other appropriate gains and losses; and

(b) The amount of pool contributions specified in the state omnibus appropriations act for deposit into the health benefit exchange account under RCW 43.71.060, to assist with the transition of enrollees from the pool into the health benefit exchange created by chapter 43.71 RCW.

(2)(a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the commissioner; and shall be determined by multiplying the total cost of pool operation by a fraction. The numerator of the fraction equals that member's total number of resident insured persons, including spouse and dependents, covered under all health plans in the state by that member during the preceding calendar year. The denominator of the fraction equals the total number of resident insured persons, including spouses and dependents, covered under all health plans in the state by all pool members during the preceding calendar year.

(b) For purposes of calculating the numerator and the denominator under (a) of this subsection:

(i) All health plans in the state by the state health care authority include only the uniform medical plan;

(ii) Each ten resident insured persons, including spouse and dependents, under a stop loss plan or the uniform medical plan shall count as one resident insured person;

(iii) Health plans serving medical care services program clients under RCW 74.09.035 are exempted from the calculation; and

(iv) Health plans established to serve elderly clients or medicaid clients with disabilities under chapter 74.09 RCW when the plan has been implemented on a demonstration or pilot project basis are exempted from the calculation until July 1, 2009.

(c) Except as provided in RCW 48.41.037, any deficit incurred by the pool, including pool contributions for deposit into the health benefit exchange account, shall be recouped by assessments among members apportioned under this subsection pursuant to the formula set forth by the board among members. The ((~~monthly per member assessment may not exceed the 2013 assessment level~~)) total of 2014 member assessments may not exceed the total of 2013 member assessments except to the extent necessary to pay a deficit incurred by the pool from pool losses and administrative expenses. If the maximum ((~~assessment is~~)) 2014 assessments are insufficient to cover a pool deficit, including contribution for deposits into the health benefit exchange account, the assessments shall be used first to pay all incurred losses and pool administrative expenses, with the remainder being available for deposit in the health benefit exchange account.

(3) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. If an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (2) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency.

(4) Subject to the limitation imposed in subsection (2)(c) of this section, the pool administrator shall transfer the assessments for pool contributions for the operation of the health benefit exchange to the treasurer for deposit into the health benefit exchange account ((~~with the quarterly assessments for~~)) in 2014 as specified in the state omnibus appropriations act. If assessments exceed actual losses and administrative expenses of the pool and pool contributions for deposit into the health benefit exchange account, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

Sec. 3. RCW 48.41.110 and 2012 c 211 s 25 are each amended to read as follows:

(1) The pool shall offer one or more care management plans of

coverage. Such plans may, but are not required to, include point of service features that permit participants to receive in-network benefits or out-of-network benefits subject to differential cost shares. The pool may incorporate managed care features into existing plans.

(2) The administrator shall prepare a brochure outlining the benefits and exclusions of pool policies in plain language. After approval by the board, such brochure shall be made reasonably available to participants or potential participants.

(3) The health insurance policies issued by the pool shall pay only reasonable amounts for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of covered illnesses, injuries, and conditions. Eligible expenses are the reasonable amounts for the health care services and items for which benefits are extended under a pool policy.

(4) The pool shall offer at least two policies, one of which will be a comprehensive policy that must comply with RCW 48.41.120 and must at a minimum include the following services or related items, except as provided in subsection (11) of this section:

(a) Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, including no less than a total of one hundred eighty inpatient days in a calendar year, and no less than thirty days inpatient care for alcohol, drug, or chemical dependency or abuse per calendar year;

(b) Professional services including surgery for the treatment of injuries, illnesses, or conditions, other than dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered or licensed practical nurses, or other health care providers;

(c) No less than twenty outpatient professional visits for the diagnosis or treatment of alcohol, drug, or chemical dependency or abuse rendered during a calendar year by a state-certified chemical dependency program approved under chapter 70.96A RCW, or by one or more physicians, psychologists, or community mental health professionals, or, at the direction of a physician, by other qualified licensed health care practitioners;

(d) Drugs and contraceptive devices requiring a prescription;

(e) Services of a skilled nursing facility, excluding custodial and convalescent care, for not less than one hundred days in a calendar year as prescribed by a physician;

(f) Services of a home health agency;

(g) Chemotherapy, radioisotope, radiation, and nuclear medicine therapy;

(h) Oxygen;

(i) Anesthesia services;

(j) Prostheses, other than dental;

(k) Durable medical equipment which has no personal use in the absence of the condition for which prescribed;

(l) Diagnostic x-rays and laboratory tests;

(m) Oral surgery including at least the following: Fractures of facial bones; excisions of mandibular joints, lesions of the mouth, lip, or tongue, tumors, or cysts excluding treatment for temporomandibular joints; incision of accessory sinuses, mouth salivary glands or ducts; dislocations of the jaw; plastic reconstruction or repair of traumatic injuries occurring while covered under the pool; and excision of impacted wisdom teeth;

(n) Maternity care services;

(o) Services of a physical therapist and services of a speech therapist;

(p) Hospice services;

(q) Professional ambulance service to the nearest health care facility qualified to treat the illness or injury;

(r) Mental health services pursuant to RCW 48.41.220; and

(s) Other medical equipment, services, or supplies required by physician's orders and medically necessary and consistent with the diagnosis, treatment, and condition.

(5) The board shall design and employ cost containment measures and requirements such as, but not limited to, care coordination, provider network limitations, preadmission certification, and concurrent inpatient review which may make the pool more cost-effective.

(6) The pool benefit policy may contain benefit limitations, exceptions, and cost shares such as copayments, coinsurance, and deductibles that are consistent with managed care products, except that differential cost shares may be adopted by the board for nonnetwork

providers under point of service plans. No limitation, exception, or reduction may be used that would exclude coverage for any disease, illness, or injury.

(7)(a) The pool may not reject an individual for health plan coverage based upon preexisting conditions of the individual or deny, exclude, or otherwise limit coverage for an individual's preexisting health conditions; except that it shall impose a six-month benefit waiting period for preexisting conditions for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within six months before the effective date of coverage. The preexisting condition waiting period shall not apply to prenatal care services or benefits for outpatient prescription drugs. The pool may not avoid the requirements of this section through the creation of a new rate classification or the modification of an existing rate classification. Credit against the waiting period shall be as provided in subsection (8) of this section.

(b) The pool shall not impose any preexisting condition waiting period for any person under the age of nineteen.

(8)(a) Except as provided in (b) of this subsection, the pool shall credit any preexisting condition waiting period in its plans for a person who was enrolled at any time during the sixty-three day period immediately preceding the date of application for the new pool plan. For the person previously enrolled in a group health benefit plan, the pool must credit the aggregate of all periods of preceding coverage not separated by more than sixty-three days toward the waiting period of the new health plan. For the person previously enrolled in an individual health benefit plan other than a catastrophic health plan, the pool must credit the period of coverage the person was continuously covered under the immediately preceding health plan toward the waiting period of the new health plan. For the purposes of this subsection, a preceding health plan includes an employer-provided self-funded health plan.

(b) The pool shall waive any preexisting condition waiting period for a person who is an eligible individual as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. 300gg-41(b)).

(9) If an application is made for the pool policy as a result of rejection by a carrier, then the date of application to the carrier, rather than to the pool, should govern for purposes of determining preexisting condition credit.

(10) The pool shall contract with organizations that provide care management that has been demonstrated to be effective and shall encourage enrollees who are eligible for care management services to participate. The pool may encourage the use of shared decision making and certified decision aids for preference-sensitive care areas.

(11) The board may modify the covered services and cost-sharing for pool policies to comply with the requirements of the affordable care act to maintain minimum essential coverage and otherwise as necessary for covered persons not to be subject to the shared responsibility payment under the affordable care act. For purposes of this subsection, "affordable care act" means the federal patient protection and affordable care act, P.L. 111-148, as amended by the federal health care and education reconciliation act of 2010, P.L. 111-152, and federal regulations and guidance issued under the affordable care act.

Sec. 4. RCW 48.41.120 and 2007 c 259 s 31 are each amended to read as follows:

(1) Subject to the limitation provided in subsection (3) of this section, the comprehensive pool policy offered under RCW 48.41.110(4) shall impose a deductible as provided in this subsection. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall initially be offered. The board may authorize deductibles in other amounts. The deductible shall be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

(2) Except as provided in subsection (5) of this section and subject to the limitations provided in subsection (3) of this section, a mandatory coinsurance requirement shall be imposed at a rate not to exceed twenty percent of eligible expenses in excess of the mandatory deductible and which supports the efficient delivery of high quality health care services for the medical conditions of pool enrollees.

(3) Except as provided in subsection (5) of this section, the maximum aggregate out of pocket payments for eligible expenses by the

insured in the form of deductibles and coinsurance under the comprehensive pool policy offered under RCW 48.41.110(4) shall not exceed in a calendar year:

(a) One thousand five hundred dollars per individual, or three thousand dollars per family, per calendar year for the five hundred dollar deductible policy;

(b) Two thousand five hundred dollars per individual, or five thousand dollars per family per calendar year for the one thousand dollar deductible policy; or

(c) An amount authorized by the board for any other deductible policy.

(4) Except for those enrolled in a high deductible health plan qualified under federal law for use with a health savings account, eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

(5) The board may modify:

(a) Cost-sharing as an incentive for enrollees to participate in care management services and other cost-effective programs and policies; and

(b) Covered services and cost-sharing pursuant to RCW 48.41.110.

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