S-1564.4

SUBSTITUTE SENATE BILL 5449

State of Washington 63rd Legislature 2013 Regular Session

By Senate Health Care (originally sponsored by Senators Parlette, Keiser, Becker, Bailey, Dammeier, Frockt, Ericksen, and Schlicher)

READ FIRST TIME 02/22/13.

AN ACT Relating to modification of the Washington state health insurance pool; amending RCW 48.41.060, 48.41.160, and 48.41.240; reenacting and amending RCW 48.41.100; creating a new section; and providing an effective date.

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

NEW SECTION. **Sec. 1.** The federal patient protection and affordable care act of 2010, P.L. 111-148, as amended, prohibits the imposition of any preexisting condition coverage exceptions in the individual market for insurance coverage beginning January 1, 2014. The affordable care act also extends opportunities for individuals to enroll in comprehensive coverage in a health benefit exchange beginning January 1, 2014. The legislature finds that some individuals may still be barred from enrolling in the new comprehensive coverage options and it is the intent of the legislature to continue some limited access to the Washington state health insurance pool for a transitional period, and to provide for modification to the pool to reflect changes in federal law and insurance availability.

Sec. 2. RCW 48.41.060 and 2011 c 314 s 13 are each amended to read as follows:

(1) The board shall have the general powers and authority granted under the laws of this state to insurance companies, health care service contractors, and health maintenance organizations, licensed or registered to offer or provide the kinds of health coverage defined under this title. In addition thereto, the board shall:

(a) ((~~Designate or establish the standard health questionnaire to be used under RCW 48.41.100 and 48.43.018, including the form and content of the standard health questionnaire and the method of its application. The questionnaire must provide for an objective evaluation of an individual's health status by assigning a discreet measure, such as a system of point scoring to each individual. The questionnaire must not contain any questions related to pregnancy, and pregnancy shall not be a basis for coverage by the pool. The questionnaire shall be designed such that it is reasonably expected to identify the eight percent of persons who are the most costly to treat who are under individual coverage in health benefit plans, as defined in RCW 48.43.005, in Washington state or are covered by the pool, if applied to all such persons;~~

~~(b) Obtain from a member of the American academy of actuaries, who is independent of the board, a certification that the standard health questionnaire meets the requirements of (a) of this subsection;~~

~~(c) Approve the standard health questionnaire and any modifications needed to comply with this chapter. The standard health questionnaire shall be submitted to an actuary for certification, modified as necessary, and approved at least every thirty-six months unless at the time when certification is required the pool will be discontinued before the end of the succeeding thirty-six month period. The designation and approval of the standard health questionnaire by the board shall not be subject to review and approval by the commissioner. The standard health questionnaire or any modification thereto shall not be used until ninety days after public notice of the approval of the questionnaire or any modification thereto, except that the initial standard health questionnaire approved for use by the board after March 23, 2000, may be used immediately following public notice of such approval;~~

((~~(d)~~)) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience, and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices consistent with Washington state individual plan rating requirements under RCW 48.44.022 and 48.46.064;

((~~(e)~~)) (b)(i) Assess members of the pool in accordance with the provisions of this chapter, and make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any interim assessments will be credited as offsets against any regular assessments due following the close of the year.

(ii) Self-funded multiple employer welfare arrangements are subject to assessment under this subsection only in the event that assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq. The arrangements and the commissioner shall initially request an advisory opinion from the United States department of labor or obtain a declaratory ruling from a federal court on the legality of imposing assessments on these arrangements before imposing the assessment. Once the legality of the assessments has been determined, the multiple employer welfare arrangement certified by the insurance commissioner must begin payment of these assessments.

(iii) If there has not been a final determination of the legality of these assessments, then beginning on the earlier of (A) the date the fourth multiple employer welfare arrangement has been certified by the insurance commissioner, or (B) April 1, 2006, the arrangement shall deposit the assessments imposed by this subsection into an interest bearing escrow account maintained by the arrangement. Upon a final determination that the assessments are not preempted by the employee retirement income security act of 1974, as amended, 29 U.S.C. Sec. 1001 et seq., all funds in the interest bearing escrow account shall be transferred to the board;

((~~(f)~~)) (c) Issue policies of health coverage in accordance with the requirements of this chapter;

((~~(g)~~)) (d) Establish procedures for the administration of the premium discount provided under RCW 48.41.200(3)(a)(iii);

((~~(h)~~)) (e) Contract with the Washington state health care authority for the administration of the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii);

((~~(i)~~)) (f) Set a reasonable fee to be paid to an insurance producer licensed in Washington state for submitting an acceptable application for enrollment in the pool; and

((~~(j)~~)) (g) Provide certification to the commissioner when assessments will exceed the threshold level established in RCW 48.41.037.

(2) In addition thereto, the board may:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter including the authority, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(c) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, policy, and other contract design, and any other function within the authority of the pool; and

(d) Conduct periodic audits to assure the general accuracy of the financial data submitted to the pool, and the board shall cause the pool to have an annual audit of its operations by an independent certified public accountant.

(3) Nothing in this section shall be construed to require or authorize the adoption of rules under chapter 34.05 RCW.

Sec. 3. RCW 48.41.100 and 2011 c 315 s 5 and 2011 c 314 s 15 are each reenacted and amended to read as follows:

(1)(a) The following persons who are residents of this state are eligible for pool coverage:

(i) ((~~Any person who provides evidence of a carrier's decision not to accept him or her for enrollment in an individual health benefit~~

~~plan as defined in RCW 48.43.005 based upon, and within ninety days of the receipt of, the results of the standard health questionnaire designated by the board and administered by health carriers under RCW 48.43.018;~~

~~(ii) Any person who continues to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator pursuant to subsection (3) of this section;~~

~~(iii) Any person who resides in a county of the state where no carrier or insurer eligible under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool, and who makes direct application to the pool~~)) Any resident of the state not eligible for medicare coverage or medicaid coverage, and residing in a county where an individual health plan other than a catastrophic health plan as defined in RCW 48.43.005 is not offered to the resident at the time of application to the pool, whether through the health benefit exchange operated pursuant to chapter 43.71 RCW or in the private insurance market, and who makes application to the pool for coverage prior to December 31, 2016;

(ii) Any resident of the state not eligible for medicare coverage, enrolled in the pool prior to December 31, 2013, shall remain eligible for pool coverage except as provided in subsections (2) and (3) of this section through December 31, 2016;

((~~(iv)~~)) (iii) Any person becoming eligible for medicare before August 1, 2009, who provides evidence of (A) a rejection for medical reasons, (B) a requirement of restrictive riders, (C) an up-rated premium, (D) a preexisting conditions limitation, or (E) lack of access to or for a comprehensive medicare supplemental insurance policy under chapter 48.66 RCW, the effect of any of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application; and

((~~(v)~~)) (iv) Any person becoming eligible for medicare on or after August 1, 2009, who does not have access to a reasonable choice of comprehensive medicare part C plans, as defined in (b) of this subsection, and who provides evidence of (A) a rejection for medical reasons, (B) a requirement of restrictive riders, (C) an up-rated

premium, (D) a preexisting conditions limitation, or (E) lack of access to or for a comprehensive medicare supplemental insurance policy under chapter 48.66 RCW, the effect of any of which is to substantially reduce coverage from that received by a person considered a standard risk by at least one member within six months of the date of application((~~; and~~

~~(vi) Any person under the age of nineteen who does not have access to individual plan open enrollment or special enrollment, as defined in RCW 48.43.005, or the federal preexisting condition insurance pool, at the time of application to the pool is eligible for the pool coverage~~)).

(b) For purposes of (a)((~~(v)~~))(iv) of this subsection (1), a person does not have access to a reasonable choice of plans unless the person has a choice of health maintenance organization or preferred provider organization medicare part C plans offered by at least three different carriers that have had provider networks in the person's county of residence for at least five years. The plan options must include coverage at least as comprehensive as a plan F medicare supplement plan combined with medicare parts A and B. The plan options must also provide access to adequate and stable provider networks that make up-to-date provider directories easily accessible on the carrier web site, and will provide them in hard copy, if requested. In addition, if no health maintenance organization or preferred provider organization plan includes the health care provider with whom the person has an established care relationship and from whom he or she has received treatment within the past twelve months, the person does not have reasonable access.

(2) The following persons are not eligible for coverage by the pool:

(a) Any person having terminated coverage in the pool unless (i) twelve months have lapsed since termination, or (ii) that person can show continuous other coverage which has been involuntarily terminated for any reason other than nonpayment of premiums. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b));

(b) Inmates of public institutions and those persons who become eligible for medical assistance after June 30, 2008, as defined in RCW

74.09.010. However, these exclusions do not apply to eligible individuals as defined in section 2741(b) of the federal health insurance portability and accountability act of 1996 (42 U.S.C. Sec. 300gg-41(b))((~~;~~

~~(c) Any person who resides in a county of the state where any carrier or insurer regulated under chapter 48.15 RCW offers to the public an individual health benefit plan other than a catastrophic health plan as defined in RCW 48.43.005 at the time of application to the pool and who does not qualify for pool coverage based upon the results of the standard health questionnaire, or pursuant to subsection (1)(a)(iv) of this section~~)).

(3) When a carrier or insurer regulated under chapter 48.15 RCW begins to offer an individual health benefit plan in a county where no carrier had been offering an individual health benefit plan:

(a) If the health benefit plan offered is other than a catastrophic health plan as defined in RCW 48.43.005, any person enrolled in a pool plan pursuant to subsection (1)(a)((~~(iii)~~)) (i) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(a)((~~(iii)~~)) (i) of this section((~~, but may continue to be eligible for pool coverage based upon the results of the standard health questionnaire designated by the board and administered by the pool administrator. The pool administrator shall offer to administer the questionnaire to each person no longer eligible for coverage under subsection (1)(a)(iii) of this section within thirty days of determining that he or she is no longer eligible;~~

~~(b) Losing eligibility for pool coverage under this subsection (3) does not affect a person's eligibility for pool coverage under subsection (1)(a)(i), (ii), or (iv) of this section~~)); and

((~~(c)~~)) (b) The pool administrator shall provide written notice to any person who is no longer eligible for coverage under a pool plan under this subsection (3) within thirty days of the administrator's determination that the person is no longer eligible. The notice shall: (i) Indicate that coverage under the plan will cease ninety days from the date that the notice is dated; (ii) describe any other coverage options, either in or outside of the pool, available to the person; and (iii) describe the ((~~procedures for the administration of the standard health questionnaire to determine the person's continued eligibility~~

~~for coverage under subsection (1)(a)(ii) of this section; and (iv) describe the~~)) enrollment process for the available options outside of the pool.

((~~(4) The board shall ensure that an independent analysis of the eligibility standards for the pool coverage is conducted, including examining the eight percent eligibility threshold, eligibility for medicaid enrollees and other publicly sponsored enrollees, and the impacts on the pool and the state budget. The board shall report the findings to the legislature by December 1, 2007.~~))

Sec. 4. RCW 48.41.160 and 2007 c 259 s 27 are each amended to read as follows:

(1) On or before December 31, 2007, the pool shall cancel all existing pool policies and replace them with policies that are identical to the existing policies except for the inclusion of a provision providing for a guarantee of the continuity of coverage consistent with this section. As a means to minimize the number of policy changes for enrollees, replacement policies provided under this subsection also may include the plan modifications authorized in RCW 48.41.100, 48.41.110, and 48.41.120.

(2) A pool policy shall contain a guarantee of the individual's right to continued coverage, subject to the provisions of subsections (4) ((~~and~~)), (5)<u>, (7), and (8)</u> of this section.

(3) The guarantee of continuity of coverage required by this section shall not prevent the pool from canceling or nonrenewing a policy for:

(a) Nonpayment of premium;

(b) Violation of published policies of the pool;

(c) Failure of a covered person who becomes eligible for medicare benefits by reason of age to apply for a pool medical supplement plan, or a medicare supplement plan or other similar plan offered by a carrier pursuant to federal laws and regulations;

(d) Failure of a covered person to pay any deductible or copayment amount owed to the pool and not the provider of health care services;

(e) Covered persons committing fraudulent acts as to the pool;

(f) Covered persons materially breaching the pool policy; or

(g) Changes adopted to federal or state laws when such changes no longer permit the continued offering of such coverage.

(4)(a) The guarantee of continuity of coverage provided by this section requires that if the pool replaces a plan, it must make the replacement plan available to all individuals in the plan being replaced. The replacement plan must include all of the services covered under the replaced plan, and must not significantly limit access to the kind of services covered under the replacement plan through unreasonable cost-sharing requirements or otherwise. The pool may also allow individuals who are covered by a plan that is being replaced an unrestricted right to transfer to a fully comparable plan.

(b) The guarantee of continuity of coverage provided by this section requires that if the pool discontinues offering a plan: (i) The pool must provide notice to each individual of the discontinuation at least ninety days prior to the date of the discontinuation; (ii) the pool must offer to each individual provided coverage under the discontinued plan the option to enroll in any other plan currently offered by the pool for which the individual is otherwise eligible; and (iii) in exercising the option to discontinue a plan and in offering the option of coverage under (b)(ii) of this subsection, the pool must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for this coverage.

(c) The pool cannot replace or discontinue a plan under this subsection (4) until it has completed an evaluation of the impact of replacing the plan upon:

(i) The cost and quality of care to pool enrollees;

(ii) Pool financing and enrollment;

(iii) The board's ability to offer comprehensive and other plans to its enrollees;

(iv) Other items identified by the board.

In its evaluation, the board must request input from the constituents represented by the board members.

(d) The guarantee of continuity of coverage provided by this section does not apply if the pool has zero enrollment in a plan.

(5) The pool may not change the rates for pool policies except on a class basis, with a clear disclosure in the policy of the pool's right to do so.

(6) A pool policy offered under this chapter shall provide that, upon the death of the individual in whose name the policy is issued,

every other individual then covered under the policy may elect, within a period specified in the policy, to continue coverage under the same or a different policy.

(7) All pool policies issued on or after January 1, 2014, must reflect the new eligibility requirements of RCW 48.41.100 and contain a statement of the intent to discontinue the pool coverage on December 31, 2016, under pool nonmedicare plans.

(8) Pool policies issued prior to January 1, 2014, shall be modified effective January 1, 2013, consistent with subsection (3)(g) of this section, and contain a statement of the intent to discontinue pool coverage on December 31, 2016, under pool nonmedicare plans.

(9) The pool shall discontinue all nonmedicare pool plans effective December 31, 2016.

Sec. 5. RCW 48.41.240 and 2012 c 87 s 17 are each amended to read as follows:

(1) The board shall review populations that may need ongoing access to coverage through the pool, with specific attention to those persons who may be excluded from or may receive inadequate coverage beginning January 1, 2014, such as persons with end-stage renal disease or HIV/AIDS, or persons not eligible for coverage in the exchange.

(2) If the review under subsection (1) of this section indicates a continued need for coverage through the pool after December 31, 2013, the board shall submit recommendations regarding any modifications to pool eligibility requirements for new and ongoing enrollment after December 31, 2013. The recommendations must address any needed modifications to the standard health questionnaire or other eligibility screening tool that could be used in a manner consistent with federal law to determine eligibility for enrollment in the pool.

(3) The board shall complete an analysis of current pool assessment requirements in relation to assessments that will fund the reinsurance program and recommend changes to pool assessments or any credits against assessments that may be considered for the reinsurance program. The analysis shall recommend whether the categories of members paying assessments should be adjusted to make the assessment fair and equitable among all payers.

(4) The board shall report its recommendations to the governor and the legislature by December 1, 2012.

(5) The board shall revisit the study of eligibility completed in 2012 with another review of the populations that may need ongoing access to coverage through the pool, to be submitted to the governor and legislature by November 1, 2015. The eligibility study shall include the nonmedicare populations scheduled to lose coverage December 2016 and medicare populations, and consider whether the enrollees have access to comprehensive coverage alternatives that include appropriate pharmacy coverage. The study shall include recommendations to address any barriers in eligibility that remain in accessing other coverage such as medicare supplemental coverage or comprehensive pharmacy coverage, as well as suggestions for financing changes and recommendations on a future expiration of the pool.

NEW SECTION. **Sec. 6.** Sections 2 and 3 of this act take effect January 1, 2014.

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