
HOUSE BILL 1700

State of Washington

64th Legislature

2015 Regular Session

By Representatives Riccelli, Manweller, Robinson, Harris, Gregerson,
and Ormsby

Read first time 01/27/15. Referred to Committee on Health Care &
Wellness.

1 AN ACT Relating to qualified health plan claims in grace periods;
2 and amending RCW 48.43.039, 43.71.065, and 43.71.090.

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

4 **Sec. 1.** RCW 48.43.039 and 2014 c 84 s 3 are each amended to read
5 as follows:

6 (1) For an enrollee who is in the second or third month of the
7 grace period, an issuer of a qualified health plan shall:

8 (a) Upon request by a health care provider or health care
9 facility, provide information regarding the enrollee's eligibility
10 status in real-time; and

11 (b) Notify a health care provider or health care facility that an
12 enrollee is in the grace period within three business days after
13 submittal of a claim or status request for services provided.

14 (2) The information or notification required under subsection (1)
15 of this section must, at a minimum:

16 (a) Indicate "grace period" or use the appropriate national
17 coding standard as the reason for pending the claim if a claim is
18 pending due to the enrollee's grace period status; and

19 (b) Except for notifications provided electronically, indicate
20 that enrollee is in the second or third month of the grace period.

1 (3) By December 1, 2014, and annually each December 1st
2 thereafter, the health benefit exchange shall provide a report to the
3 appropriate committees of the legislature with the following
4 information for the calendar year: (a) The number of exchange
5 enrollees who entered the grace period; (b) the number of enrollees
6 who subsequently paid premium after entering the grace period; (c)
7 the average number of days enrollees were in the grace period prior
8 to paying premium; and (d) the number of enrollees who were in the
9 grace period and whose coverage was terminated due to nonpayment of
10 premium. The report must include as much data as is available for the
11 calendar year.

12 (4) By January 1, 2017, and thereafter, an issuer of a qualified
13 health plan shall reimburse a health care provider or a health care
14 facility for all nonfraudulent claims for service provided to an
15 enrollee during the grace period. Reimbursement may not be recouped
16 due to enrollee nonpayment of premiums.

17 (5) For purposes of this section, "grace period" means nonpayment
18 of premiums by an enrollee receiving advance payments of the premium
19 tax credit, as defined in section 1412 of the patient protection and
20 affordable care act, P.L. 111-148, as amended by the health care and
21 education reconciliation act, P.L. 111-152, and implementing
22 regulations issued by the federal department of health and human
23 services.

24 **Sec. 2.** RCW 43.71.065 and 2012 c 87 s 8 are each amended to read
25 as follows:

26 (1) The board shall certify a plan as a qualified health plan to
27 be offered through the exchange if the plan is determined by the:

28 (a) Insurance commissioner to meet the requirements of Title 48
29 RCW and rules adopted by the commissioner pursuant to chapter 34.05
30 RCW to implement the requirements of Title 48 RCW;

31 (b) Board to meet the requirements of the affordable care act for
32 certification as a qualified health plan; (~~and~~)

33 (c) Board to ensure adherence to the terms of the contract
34 between the qualified health plan issuer and a health care provider
35 or health care facility, including a qualified health plan issuer
36 reimbursing a health care provider or health care facility for
37 nonfraudulent claims for service provided to an enrollee during the
38 grace period, as defined in section 1412 of the patient protection
39 and affordable care act, P.L. 111-148, as amended by the health care

1 and education reconciliation act, P.L. 111-152, and implementing
2 regulations issued by the federal department of health and human
3 services; and

4 (d) Board to include tribal clinics and urban Indian clinics as
5 essential community providers in the plan's provider network
6 consistent with federal law. If consistent with federal law,
7 integrated delivery systems shall be exempt from the requirement to
8 include essential community providers in the provider network.

9 (2) Consistent with section 1311 of P.L. 111-148 of 2010, as
10 amended, the board shall allow stand-alone dental plans to offer
11 coverage in the exchange beginning January 1, 2014. Dental benefits
12 offered in the exchange must be offered and priced separately to
13 assure transparency for consumers.

14 (3) The board may permit direct primary care medical home plans,
15 consistent with section 1301 of P.L. 111-148 of 2010, as amended, to
16 be offered in the exchange beginning January 1, 2014.

17 (4) Upon request by the board, a state agency shall provide
18 information to the board for its use in determining if the
19 requirements under subsection (1)(b) or ~~((e))~~ (d) of this section
20 have been met. Unless the agency and the board agree to a later date,
21 the agency shall provide the information within sixty days of the
22 request. The exchange shall reimburse the agency for the cost of
23 compiling and providing the requested information within one hundred
24 eighty days of its receipt.

25 (5) A decision by the board denying a request to certify or
26 recertify a plan as a qualified health plan may be appealed according
27 to procedures adopted by the board.

28 **Sec. 3.** RCW 43.71.090 and 2014 c 84 s 1 are each amended to read
29 as follows:

30 (1) The exchange must support the grace period by providing
31 electronic information to an issuer of a qualified health plan or a
32 qualified dental plan that complies with 45 C.F.R. Sec. 156.270
33 (2013) and 45 C.F.R. Sec. 155.430 (2013).

34 ~~((If the health benefit exchange notifies an enrollee that he~~
35 ~~or she is delinquent on payment of premium, the notice must include~~
36 ~~information on how to report a change in income or circumstances and~~
37 ~~an explanation that such a report may result in a change in the~~
38 ~~premium amount or program eligibility.)) Prior to terminating the
39 coverage of an enrollee receiving advance payments of the premium tax~~

1 credit, the health benefit exchange shall conduct outreach with the
2 specific goal of ensuring that enrollees who are late in making
3 premium payments are aware that they may be eligible for medicaid
4 coverage or for an increased subsidy level in the health benefit
5 exchange. Where possible, this outreach must include correspondence
6 via mail, email, and telephone.

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