H-4076.4

SUBSTITUTE HOUSE BILL 2340

State of Washington 64th Legislature 2016 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Schmick, Cody, and Jinkins)

READ FIRST TIME 02/05/16.

AN ACT Relating to the Washington state health insurance pool; amending RCW 48.41.100, 48.41.160, and 48.41.090; and creating a new section.

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

Sec. 1. RCW 48.41.100 and 2013 c 279 s 3 are each amended to read as follows:

(1)(a) Subject to subsection (4) of this section, the following persons who are residents of this state are eligible for pool coverage:

(i) 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 during defined open enrollment or special enrollment periods 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, ((~~2017~~)) 2018;

(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, ((~~2017~~)) 2018;

(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

(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.

(b) For purposes of (a)(i) of this subsection, by December 1, 2013, the board shall develop and implement a process to determine an applicant's eligibility based on the criteria specified in (a)(i) of this subsection.

(c) For purposes of (a)(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)).

(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)(i) of this section in that county shall no longer be eligible for coverage under that plan pursuant to subsection (1)(a)(i) of this section; and

(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 enrollment process for the available options outside of the pool.

(4) The pool shall freeze enrollment for all nonmedicare plans until August 1, 2017.

Sec. 2. RCW 48.41.160 and 2013 c 279 s 4 are each amended to read as follows:

1 (1) On or before December 31, 2007, the pool shall cancel all
2 existing pool policies and replace them with policies that are
3 identical to the existing policies except for the inclusion of a
4 provision providing for a guarantee of the continuity of coverage
5 consistent with this section. As a means to minimize the number of
6 policy changes for enrollees, replacement policies provided under
7 this subsection also may include the plan modifications authorized in
8 RCW 48.41.100, 48.41.110, and 48.41.120.
9 (2) A pool policy shall contain a guarantee of the individual's
10 right to continued coverage, subject to the provisions of subsections
11 (4), (5), (7), and (8) of this section.
12 (3) The guarantee of continuity of coverage required by this
13 section shall not prevent the pool from canceling or nonrenewing a
14 policy for:
15 (a) Nonpayment of premium;
16 (b) Violation of published policies of the pool;
17 (c) Failure of a covered person who becomes eligible for medicare
18 benefits by reason of age to apply for a pool medical supplement
19 plan, or a medicare supplement plan or other similar plan offered by
20 a carrier pursuant to federal laws and regulations;
21 (d) Failure of a covered person to pay any deductible or
22 copayment amount owed to the pool and not the provider of health care
23 services;
24 (e) Covered persons committing fraudulent acts as to the pool;
25 (f) Covered persons materially breaching the pool policy; or
26 (g) Changes adopted to federal or state laws when such changes no
27 longer permit the continued offering of such coverage.
28 (4)(a) The guarantee of continuity of coverage provided by this
29 section requires that if the pool replaces a plan, it must make the
30 replacement plan available to all individuals in the plan being
31 replaced. The replacement plan must include all of the services
32 covered under the replaced plan, and must not significantly limit
33 access to the kind of services covered under the replacement plan
34 through unreasonable cost-sharing requirements or otherwise. The pool
35 may also allow individuals who are covered by a plan that is being
36 replaced an unrestricted right to transfer to a fully comparable
37 plan.
38 (b) The guarantee of continuity of coverage provided by this
39 section requires that if the pool discontinues offering a plan: (i)
40 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, ((~~2017~~)) 2018, 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, ((~~2017~~)) 2018, under pool nonmedicare plans.

(9) The pool shall discontinue all nonmedicare pool plans effective December 31, ((~~2017~~)) 2018.

Sec. 3. 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~~)) five 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) Each seven resident insured persons, including spouse and dependents, under the uniform medical plan shall count as one resident insured person;

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

((~~(iv)~~)) (v) 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. If the maximum assessment is insufficient to cover a pool deficit the assessment 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 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.

NEW SECTION. **Sec. 4.** The legislature intends that the funding of the Washington state health insurance pool be examined during the period that pool enrollment is frozen. A work group must analyze the program and all available options to fund the pool. The work group may not consist of more than fifteen members and members may not be

1 compensated. The work group shall consult with the legislature. The
2 work group must complete its work by December 1, 2016, and must be
3 funded within existing resources of the pool.

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