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**HOUSE BILL 2228**

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**State of Washington 65th Legislature 2017 2nd Special Session**

**By** Representatives J. Walsh, Schmick, Maycumber, Kraft, and Kretz

AN ACT Relating to incentivizing participation in the Washington individual health insurance market in certain counties; amending RCW 43.71.065; adding a new section to chapter 48.43 RCW; creating new sections; and declaring an emergency.

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

NEW SECTION. **Sec.**  (1) The legislature finds that:

(a) The establishment of Washington's health benefit exchange was intended to increase the availability of health care coverage through the private health insurance market and improve consumer choice;

(b) Increasing premiums and decreasing carrier participation in the health insurance marketplace have left multiple counties with no insurance carrier either on or off the health benefit exchange, leaving thousands of Washingtonians with no access to health insurance; and

(c) The state has imposed excess health insurance mandates upon carriers that provide a disincentive to offer plans in certain regions.

(2) The legislature therefore intends to reduce state health insurance mandates in counties with one or fewer health plans offered in the individual market in order to incentivize insurers to reenter the marketplace and revitalize competition and consumer choice.

NEW SECTION. **Sec.**  A new section is added to chapter 48.43 RCW to read as follows:

(1) Beginning with filings for the 2018 plan year, if the commissioner has received one or fewer filings for individual market health plans to be offered in a particular county by the standard filing deadline, the commissioner must extend the filing deadline by at least sixty days for plans to be offered in that county.

(2) The commissioner shall approve filings received during the extension period for plans to be offered in a county identified in subsection (1) of this section if the filings meet the minimum standards required by federal law with respect to mandated health benefits and provider networks. Health plans approved under this subsection are exempt from RCW 48.43.700 and any state requirements related to mandated health benefits and provider networks in excess of federal requirements. The commissioner shall continue to approve filings under this subsection for subsequent plan years until he or she receives filings for at least three individual market health plans to be offered in the county.

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

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

(a) Insurance commissioner to meet the requirements of Title 48 RCW and rules adopted by the commissioner pursuant to chapter 34.05 RCW to implement the requirements of Title 48 RCW, except as provided in section 2 of this act;

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

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

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

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

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

(5) 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.

NEW SECTION. **Sec.**  This act may be known and cited as the Washington patient choice restoration act.

NEW SECTION. **Sec.**  This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately.

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