HOUSE BILL REPORT
ESSB 5122

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to changes for implementation of the affordable care act in Washington state.

Brief Description: Making the necessary changes for implementation of the affordable care act in Washington state.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Keiser and Kline; by request of Insurance Commissioner).

Brief History:
Committee Activity:
Health Care & Wellness: 3/17/11, 3/21/11 [DP].

Brief Summary of Engrossed Substitute Bill

- Makes changes to various health insurance provisions in light of federal health care reform.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 9 members: Representatives Cody, Chair; Jinkins, Vice Chair; Schmick, Ranking Minority Member; Hinkle, Assistant Ranking Minority Member; Clibborn, Green, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 2 members: Representatives Bailey and Harris.

Staff: Jim Morishima (786-7191).

Background:

In 2010 Congress passed, and the President signed, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (PPACA). Many of the PPACA's provisions do not go into effect until 2014. However, several health insurance-

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related provisions, and the administrative rules implementing them, have already gone into effect or will go into effect in the near future. These provisions include:

- minimum medical loss ratios;
- the removal of pre-existing condition exclusions for children under the age of 19;
- the removal of lifetime maximums;
- internal and external review processes;
- mandatory coverage for emergency services;
- dependent coverage until age 26; and
- mandated coverage for preventive services.

I. Medical Loss Ratios.

A. Medical Loss Ratios Under Federal Law.

A medical loss ratio is the amount that a health insurer must spend on health care as opposed to overhead and other expenses. Under the PPACA, health insurers in the large group market must maintain a minimum 85 percent medical loss ratio. Insurers in the small group and individual markets must maintain a minimum 80 percent medical loss ratio. A health insurer that does not meet the minimum medical loss ratios must provide a rebate to each of its enrollees.

B. Medical Loss Ratios and the Washington State Health Insurance Pool.

The Washington State Health Insurance Pool (WSHIP) provides health insurance to individuals who have been rejected from the individual market based on the Standard Health Questionnaire. The WSHIP is funded, in part, by remittances that health insurers must make if their medical loss ratios are less than an amount between 74 and 77 percent (the applicable medical loss ratio is dependent on an individual insurer's declination rate).

II. Preexisting Condition Exclusions.

A. Preexisting Condition Exclusions Under Federal Law.

The PPACA currently prohibits health insurers from imposing preexisting condition exclusions on persons under the age of 19. Beginning in 2014, this prohibition will apply to all consumers.

B. Preexisting Condition Exclusions Under State Law

Generally, health insurers who offer conversion contracts or policies, i.e., a contract or policy that converts group coverage to individual coverage, may not exclude preexisting conditions. However, a preexisting condition exclusion is allowed to the extent that any waiting period in the original group coverage for a preexisting condition has not been satisfied.

III. Lifetime Maximums.

A. Lifetime Maximums Under Federal Law.

Under the PPACA, health insurers may not impose lifetime benefit maximums.

B. Lifetime Maximums Under State Law.

A group or blanket disability insurer who offers a conversion policy must offer at least three policy benefit plans:

- a major medical plan with a lifetime benefit maximum of $250,000 per person;
- a comprehensive medical plan with a lifetime benefit maximum of $500,000 per person; and
- a basic medical plan with a lifetime benefit maximum of $75,000 per person.

Individuals participating in the WSHIP are not eligible for coverage once the WSHIP has paid out $2 million in benefits.

IV. Internal and External Review Procedures.

A. Internal and External Review Procedures Under Federal Law.

1. Internal Review.

Under the PPACA, health insurers must have an effective internal appeals process for appeals of coverage determinations and claims. Enrollees must be informed of the appeals process in a culturally and linguistically appropriate manner. Enrollees must also be informed of any applicable office of health insurance consumer assistance or ombudsman established under the federal Public Health Service Act.

Notice of an adverse benefit determination must contain the following information:

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and
- the reason or reasons for the adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

2. External Review.

The PPACA also requires health insurers to comply with applicable state external review processes that contain at least the protections in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners. Additionally, the federal rules adopted to implement the PPACA require the external review process to meet the following criteria:

- The independent review organization (IRO) involved in the review may not have any conflicts of interest.
- Claimants must be provided with at least five business days to submit additional information to the IRO, which the IRO must forward to the carrier within one business day.

- The IRO must provide notice of its decision within 45 days of the request for external review.
- An expedited review process must be available for determinations regarding admissions, availability of care, continued stay, health care services for which the claimant received emergency services, but has not been discharged, or medical conditions for which a 45-day wait would jeopardize the life, health, or function of the claimant. The IRO must provide notice of its decision within 72 hours. If the notice is not in writing, the notice must be followed by written confirmation within 48 hours.
- With respect to claims involving experimental or investigational treatments, the IRO must provide protections to ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.
- The IRO must maintain written records that are available to the state.

B. Internal and External Review Procedures Under State Law.

1. Internal Review.

Every health insurer must have a fully operational, comprehensive grievance process. An insurer must respond to an enrollee's dissatisfaction about customer service or health service availability in a timely and thorough manner. Enrollees must be provided with written notice of decisions to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits. Appeals of adverse decisions must be processed within 30 days (or 72 hours if the 30-day timeline could seriously jeopardize the enrollee's life, health, or function). An insurer must make its grievance process accessible to enrollees who are limited English speakers, have disabilities, or have physical or mental disabilities.

2. External Review.

Once a health insurer's grievance process has been exhausted, the enrollee may seek review by an IRO. The Office of the Insurance Commissioner maintains a rotational registry for the assignment of an IRO to each dispute. The IRO may override the insurer's medical necessity or appropriateness standards if the standards are unreasonable or inconsistent with sound, evidence-based medical practice.

V. Emergency Services.

A. Emergency Services Under Federal Law.

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), which was passed by Congress in 1986, a hospital may not turn away a patient who comes to the emergency department with an emergency medical condition. The hospital must screen and evaluate the patient and provide treatment necessary to stabilize him or her.

Under the PPACA, a health insurer that offers coverage for services in an emergency department must cover emergency services without prior authorization, without regard to whether the provider is in-network or out-of-network, and with no differential copayments or coinsurance for out-of-network services. The services must be provided without regard to

any other term or condition of coverage other than applicable cost sharing or federally authorized waiting periods or exclusion or coordinated benefits.

For purposes of the PPACA and the EMTALA, "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or, in the case of a pregnant woman, her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any body organ or part.

B. Emergency Services Under State Law.

A health carrier must cover emergency services (services medically necessary to evaluate and treat an emergency medical condition provided in a hospital's emergency department) necessary to screen and stabilize a covered person without prior authorization if a prudent layperson would reasonably have believed that an emergency medical condition existed. If the emergency services were provided in a non-participating hospital, the health carrier must cover emergency services necessary to screen and stabilize a covered person if a prudent layperson would reasonably have believed that use of a participating hospital would result in a delay that would worsen the emergency or if use of a specific hospital is required by federal, state, or local law. Likewise, a health carrier may not require prior authorization of emergency services in a non-participating hospital if a prudent layperson acting reasonably would have believed that an emergency medical condition existed and that use of a participating hospital would result in a delay that would worsen the emergency.

If an authorized representative of the health carrier authorizes coverage for emergency services, the carrier may not retract the authorization after the services have been provided or reduce payment for services provided in reliance on the approval. The carrier may retract the authorization or reduce payment, however, if the approval was based on a material misrepresentation about the covered person's health condition made by the provider.

Coverage of emergency services may be subject to applicable copayments, coinsurance, and deductibles. A health carrier may also impose reasonable differential cost-sharing arrangements for emergency services rendered by non-participating providers. However, the difference between cost-sharing amounts for participating and non-participating providers may not exceed $50. Differential cost-sharing may not be applied when a covered person utilizes a non-participating hospital emergency department when the carrier requires pre-authorization for post-evaluation and post-stabilization emergency services if:

- the covered person was unable to go to a participating hospital in a timely fashion without serious impairment to the person's health due to circumstances beyond the person's control; or
- a prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that the person would be unable to go to a participating hospital in a timely fashion without serious impairment to the person's health.

"Emergency medical condition" is defined as the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

VI. Dependent Coverage to Age 26.

A. Dependent Coverage Under Federal Law.

Under the PPACA, if a health insurer offers dependent coverage, a child may stay on the parent's plan until age 26, unless the child's employer offers health insurance.

B. Dependent Coverage Under State Law.

Health insurers who offer dependent coverage must offer the option of covering any unmarried dependent under the age of 25. Health insurers participating in the WSHIP must terminate coverage for unmarried dependents at age 19.

VII. Preventive Services.

A. Preventive Services Under Federal Law.

Under the PPACA, group or individual health insurers must provide coverage with no cost sharing requirements for a variety of preventive health services, including:

- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children, and adolescents, evidence-informed preventive care and screening provided in the comprehensive guidelines supported by the Health Resources and Services Administration;
- with respect to women, additional preventive care and screenings provided in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- evidence-based recommendations rated "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), which include tobacco use counseling and interventions.

B. Preventive Services Under State Law.

Conversion agreements may contain provisions requiring reasonable deductibles and copayments. There is currently no exemption to this option for preventive services.

Summary of Bill:

I. Medical Loss Ratios.

Provisions requiring health insurers to remit amounts to the WSHIP based on medical loss ratios are eliminated.

Exceptions are made to provisions regarding updating the Standard Health Questionnaire and selecting the new administrator for the WSHIP in the event the WSHIP will be discontinued.

II. Preexisting Condition Exclusions.

Conversion contracts and conversion policies may not contain exclusions for preexisting conditions for any applicant who is under the age of 19.

III. Lifetime Maximums.

Lifetime benefit maximums for conversion policies offered by group or blanket disability insurers are eliminated. The $2 million limit for persons participating in the WSHIP is eliminated.

IV. Internal and External Review Procedures.

A. Internal Review.

When adopting rules on internal grievance processes, the Insurance Commissioner must consider grievance processes as approved by the federal Department of Labor and Human Services or the federal Department of Labor (unless the health plans are grandfathered).

B. External Review.

The following changes are made to the IRO process:

- An IRO involved in a review may not have any conflicts of interest.
- Enrollees must be provided with at least five business days to submit additional information to the IRO, which the IRO must forward to the carrier within one business day.
- An expedited review process must be available for determinations regarding admissions, availability of care, continued stay, health care services for which the claimant received emergency services, but has not been discharged, or medical conditions for which a 45-day wait would jeopardize the life, health, or function of the claimant. The IRO must provide notice of its decision within 72 hours. If the notice is not in writing, the notice must be followed by written confirmation within 48 hours.
- With respect to claims involving experimental or investigational treatments, the IRO must provide protections to ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.
- The IRO must maintain written records that are available to the state.
- The Insurance Commissioner must consider standards adopted by the National Association of Insurance Commissioners when promulgating rules regarding IROs.

V. Emergency Services.

The definition of "emergency services" is changed to reflect the definition in the EMTALA and the PPACA; i.e., services necessary to screen, evaluate, and stabilize the patient.

The definition of "emergency medical condition" is changed to reflect the definition in the EMTALA and the PPACA; i.e., a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition:

- placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

VI. Dependent Coverage to Age 26.

Health insurers who offer dependent coverage must offer the option of covering any dependent under the age of 26. Health insurers in the WSHIP must terminate dependent coverage at age 26.

VII. Preventive Services.

Conversion agreements may not require deductibles or copayments for preventive services.

Appropriation: None.

Fiscal Note: Available on original bill.

Effective Date: The bill takes effect 90 days after adjournment of session in which the bill is passed, except for sections 10 through 12, dealing with remittances to the Washington State Health Insurance Pool, which take effect January 1, 2012.

Staff Summary of Public Testimony:

(In support) This bill harmonizes state law with federal law. The bill aligns administrative details of Washington's state statutes with federal requirements; e.g., federal law requires dependent coverage to age 26, but Washington requires coverage to age 25.

(Opposed) None.

Persons Testifying: Senator Keiser, prime sponsor.

Persons Signed In To Testify But Not Testifying: None.