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**HOUSE BILL 1700**

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**State of Washington 64th Legislature 2015 Regular Session**

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

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

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

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

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

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

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

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

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

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

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

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

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

**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;

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

(c) Board to ensure adherence to the terms of the contract between the qualified health plan issuer and a health care provider or health care facility, including a qualified health plan issuer reimbursing a health care provider or health care facility for nonfraudulent claims for service provided to an enrollee during the grace period, as defined in section 1412 of the patient protection and affordable care act, P.L. 111-148, as amended by the health care and education reconciliation act, P.L. 111-152, and implementing regulations issued by the federal department of health and human services; and

(d) 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)~~))(d) 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.

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

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

(2) ((~~If the health benefit exchange notifies an enrollee that he or she is delinquent on payment of premium, the notice must include information on how to report a change in income or circumstances and an explanation that such a report may result in a change in the premium amount or program eligibility.~~))Prior to terminating the coverage of an enrollee receiving advance payments of the premium tax credit, the health benefit exchange shall conduct outreach with the specific goal of ensuring that enrollees who are late in making premium payments are aware that they may be eligible for medicaid coverage or for an increased subsidy level in the health benefit exchange. Where possible, this outreach must include correspondence via mail, email, and telephone.

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