S-3887.1

SENATE BILL 6464

State of Washington 63rd Legislature 2014 Regular Session

By Senators O'Ban, Parlette, and Becker

AN ACT Relating to broadening health insurance coverage options for the citizens of Washington; amending RCW 48.43.700, 48.43.705, and 48.43.715; adding new sections to chapter 48.43 RCW; and creating a new section.

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

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

(a) Because of the federal patient protection and affordable care act, also known as Obamacare, millions of Americans, many of whom live in Washington, had their health insurance plans canceled despite President Obama's promise that they could keep the coverage they had.

(b) The Obama administration responded to this problem in the following ways:

(i) Allowing state insurance commissioners, for a period of one year, to approve plans that do not meet the requirements of Obamacare;

(ii) Suspending the individual mandate for persons whose insurance was canceled due to Obamacare; and

(iii) Allowing persons whose insurance was canceled due to Obamacare to purchase catastrophic insurance, regardless of age.

(c) The solutions offered by the Obama administration are insufficient for Washington citizens due to:

(i) The Washington insurance commissioner's refusal to approve plans that do not meet the requirements of Obamacare; and

(ii) The nonexistence or limited availability of the coverage alternatives proposed by the Obama administration in response to the crisis.

(2) The legislature, therefore, intends to expand affordable coverage options for Washington citizens by:

(a) Allowing health carriers to continue to offer certain individual or small group health plans in the market outside of the exchange, regardless of whether the plans meet the requirements of Obamacare; and

(b) Allowing out-of-state carriers to offer insurance products in Washington.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) A health carrier may continue to offer an individual or small group health plan in the market outside of the exchange, regardless of whether the plan meets any state or federal requirements applicable to individual or small group plans offered on or after October 1, 2013, if:

(a) The health plan was offered in the individual or small group market in Washington on October 1, 2013; and

(b) The purchaser of the health plan was actually enrolled in the plan on October 1, 2013.

(2) A health carrier choosing to continue to offer an individual or small group health plan under subsection (1) of this section, shall send written notice to all enrollees of that plan who have received a cancellation or termination notice regarding the plan, or who otherwise should have received such notice, informing them of:

(a) Any changes in the options available to them;

(b) Which market reforms would not be reflected in any continued coverage;

(c) Their potential right to enroll in a qualified health plan offered through the exchange and possibly qualify for financial assistance;

(d) How to access such coverage through the exchange; and

(e) Their right to enroll in health insurance coverage outside of the exchange that complies with the market reforms identified in (b) of this subsection.

(3) The commissioner may not adopt any rules or policies that would prohibit or inhibit continuing coverage under this section.

Sec. 3. RCW 48.43.700 and 2012 c 87 s 6 are each amended to read as follows:

(1) For plan or policy years beginning January 1, 2014, a carrier must offer individual or small group health benefit plans that meet the definition of silver and gold level plans in section 1302 of P.L. 111-148 of 2010, as amended, in any market outside the exchange in which it offers a plan that meets the definition of bronze level in section 1302 of P.L. 111-148 of 2010, as amended.

(2) Except as provided in section 2 of this act, a health benefit plan meeting the definition of a catastrophic plan in RCW 48.43.005(8)(c)(i) may only be sold through the exchange.

(3) By December 1, 2016, the exchange board, in consultation with the commissioner, must complete a review of the impact of this section on the health and viability of the markets inside and outside the exchange and submit the recommendations to the legislature on whether to maintain the market rules or let them expire.

(4) The commissioner shall evaluate plans offered at each actuarial value defined in section 1302 of P.L. 111-148 of 2010, as amended, and determine whether variation in prescription drug benefit cost-sharing, both inside and outside the exchange in both the individual and small group markets results in adverse selection. If so, the commissioner may adopt rules to assure substantial equivalence of prescription drug cost-sharing. Any rules adopted under this subsection do not apply to health plans offered under section 2 of this act.

Sec. 4. RCW 48.43.705 and 2012 c 87 s 7 are each amended to read as follows:

Except as provided in section 2 of this act, all health plans, other than catastrophic health plans, offered outside of the exchange must conform with the actuarial value tiers specified in section 1302

of P.L. 111-148 of 2010, as amended, as bronze, silver, gold, or platinum.

Sec. 5. RCW 48.43.715 and 2013 c 325 s 1 are each amended to read as follows:

(1) Consistent with federal law, the commissioner, in consultation with the board and the health care authority, shall, by rule, select the largest small group plan in the state by enrollment as the benchmark plan for the individual and small group market for purposes of establishing the essential health benefits in Washington state under P.L. 111-148 of 2010, as amended.

(2) If the essential health benefits benchmark plan for the individual and small group market does not include all of the ten benefit categories specified by section 1302 of P.L. 111-148, as amended, the commissioner, in consultation with the board and the health care authority, shall, by rule, supplement the benchmark plan benefits as needed to meet the minimum requirements of section 1302.

(3) Except as provided in section 2 of this act, a health plan required to offer the essential health benefits, other than a health plan offered through the federal basic health program or medicaid, under P.L. 111-148 of 2010, as amended, may not be offered in the state unless the commissioner finds that it is substantially equal to the benchmark plan. When making this determination, the commissioner:

(a) Must ensure that the plan covers the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended;

(b) May consider whether the health plan has a benefit design that would create a risk of biased selection based on health status and whether the health plan contains meaningful scope and level of benefits in each of the ten essential health benefit categories specified by section 1302 of P.L. 111-148 of 2010, as amended;

(c) Notwithstanding ((~~the foregoing~~)) this subsection, for benefit years beginning January 1, 2015, and only to the extent permitted by federal law and guidance, must establish by rule the review and approval requirements and procedures for pediatric oral services when offered in stand-alone dental plans in the nongrandfathered individual and small group markets outside of the exchange; and

(d) Unless prohibited by federal law and guidance, must allow health carriers to also offer pediatric oral services within the health benefit plan in the nongrandfathered individual and small group markets outside of the exchange.

(4) Beginning December 15, 2012, and every year thereafter, the commissioner shall submit to the legislature a list of state-mandated health benefits, the enforcement of which will result in federally imposed costs to the state related to the plans sold through the exchange because the benefits are not included in the essential health benefits designated under federal law. The list must include the anticipated costs to the state of each state-mandated health benefit on the list and any statutory changes needed if funds are not appropriated to defray the state costs for the listed mandate. The commissioner may enforce a mandate on the list for the entire market only if funds are appropriated in an omnibus appropriations act specifically to pay the state portion of the identified costs.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.43 RCW to read as follows:

A health carrier from another state may offer individual or small group health plans in Washington, regardless of whether the plans meet the requirements of this title or any rules adopted by the commissioner, if the plans meet all applicable requirements in the carrier's home state.

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