

2019 Legislative Agenda

Updated: June 5, 2018

Surprise billing

This legislation will prohibit surprise billing when the patient receives medical care at an out-of-network emergency room, for a true emergency and when the patient has an approved surgery at an in-network hospital or surgery center, but receives services (such as anesthesiology, radiology or labs) that are out-of-network.

Disaster resiliency working group

This legislation will create a work group, composed of legislators, state agencies, insurance companies and other key stakeholders, to review and make recommendations on how best to coordinate and improve disaster resiliency work in Washington State, including whether or not to create one place to do that coordinating and planning function.

Medicare access and CHIP Reauthorization Act of 2015 (MACRA)

This legislation will keep Washington State in compliance with recent changes in the Medicare and Children's Health Insurance Program (CHIP) statutes, which seek to prevent overutilization of services. The two key changes are:

1. Allow, but not require, companies to offer a new Plan G with a High Deductible option. Currently, only Plan F has an additional High Deductible option, and,
2. New enrollees, as of January 1, 2020, will no longer be able to purchase a Medicare Supplement Plan which provides coverage for the Part B deductible.

Washington must have these changes in place by January 1, 2020.

Criminal Investigations Unit (CIU) Separate Funding

This legislation will create a new and separate funding source for the Office of the Insurance Commissioner's Criminal Investigation Unit, and increase that funding to allow CIU to keep up with the increasing amount of fraud referrals by adding 6 new staff. The funding will be done by dedicating a portion of the premium surcharge already collected, to CIU exclusively.

NAIC Cybersecurity Model Law

This legislation will adopt the National Association of Insurance Commissioners (NAIC) model law on insurance cybersecurity. The model law creates a minimum standard the insurance companies must meet to assure regulators that they can protect consumer information in their possession AND their own fiduciary information and their overall operations, from cyber-attacks.

Surprise Billing Fact Sheet

Updated June 15, 2018

The Office of the Insurance Commissioner believes consumers should not be caught in the middle of billing disputes between insurers and providers. This legislation would protect people from getting a surprise medical bill when they receive emergency services at an out-of-network emergency room, or surgical or ancillary services at an in-network hospital or ambulatory surgical facility, from an out-of-network provider. If approved, the bill would take effect July 1, 2019.

To date, over twenty states have enacted legislation to prohibit surprise billing in some circumstances. Missouri and New Hampshire passed bills earlier in 2018.

Consumers taken out of middle

Patients often do not know if they are receiving treatment from an in-network or out-of-network provider, such as anesthesiologists or radiologists, during an emergency, or even during a scheduled surgery at an in-network facility. Patients too often receive care or services from a medical provider who is not included in the network of providers for their health insurance plan. This can result in consumers receiving hundreds and even thousands of dollars in bills that they are responsible for after their insurance plan has paid.

Current state law does not require an out-of-network medical provider to accept the rate the insurer pays. They can bill consumers for the difference between what the insurer pays and their full billed charges.

Bill highlights:

- Covers services delivered in emergency rooms and facilities where surgical or ancillary care is provided by out-of-network providers.
- Uses information in the Washington State All Payer Claims Database (APCD) to determine reasonable reimbursement rates.
- Establishes arbitration for providers and insurers to resolve disputes regarding reimbursement rates for out-of-network services.
- Requires issuers, providers and hospitals to provide health care consumers with information about who is in their health plan's network.

Information about surprise billing in Washington State

- According to the All Payers Claims Database (APCD), among higher volume surgery, anesthesiology and radiology services provided in 2015-2016, 4-5% of these services are provided by out-of-network providers.
- For these higher volume services, a patient who is balance-billed would pay 4-5 times the amount paid if the service was provided by an in-network provider¹ :
 - Surgery: \$568 per service out-of-network versus \$136 in-network
 - Anesthesiology: \$649 per service out-of-network versus \$119 in-network
 - Radiology: \$125 per service out-of-network versus \$28 in-network.

¹ Based on average amount of co-pay and/or coinsurance in a patients plan.

MACRA (Medicare Access and CHIP Reauthorization Act of 2015)

June 19, 2018

Background

The Federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibits the sale of any Medicare Supplement plans that cover Part B deductibles to people who are newly eligible for Medicare on or after January 1, 2020. The intent of this change is to reduce medical overuse, by requiring all newly eligible Medicare members to pay their part B deductibles.

This law has **NO** effect on individuals who are currently eligible for Medicare. Currently, Plans C and F are the only plans that cover the Part B deductible. Anyone enrolled in Medicare Supplement Plans C or F as of December 31, 2019, will be able to continue to purchase or transfer to these plans as available in the marketplace.

MACRA also requires that any guaranteed issue requirements which apply to Plans C and F be applied to Plans D and G, respectively. And, MACRA allows, but does not require, companies to offer a new Plan G with High Deductible option. Previously, only Plan F had an additional High Deductible option.

Why must we implement these changes?

- States that want to retain regulatory authority over Medicare Supplement products in their state are required to implement any changes to federal laws impacting Medicare Supplement policies.
- Failure to adopt the current laws could result in a state losing regulatory authority over these products. Authority to regulate these products would revert back to the Federal Government.

Why a statutory change in Washington?

- In Washington, the language pertaining to plan offering and guaranteed issue is contained in Revised Code of Washington (RCW) 48.66.045 and RCW 48.66.055(4)(e). These statutes **must** be changed to comply with MACRA. We will also need to make some changes in our rules.
- In the majority of states, MACRA changes can be done by rule alone, in their implemented version of the NAIC Medicare Supplement Model Regulation.

Consumer impact

- Individuals who are newly eligible for Medicare on or after January 1, 2020, will no longer be able to purchase Medicare Supplement Plan C or F.
- Individuals who are eligible for Medicare prior to January 1, 2020, will see **no change** regarding Plans C or F and will be able to continue to purchase or transfer to these plans as available in the marketplace.
- All Medicare enrollees, regardless of initial edibility date, will be able to purchase new Medicare Supplement Plan G with High Deductible, as available in the marketplace.

NAIC Cybersecurity Model Law

June 19, 2018

Background

In recent years, there have been several major data breaches involving large insurers that have exposed the sensitive personally identifiable information (PII) of millions of insurance consumers. As a result, state insurance regulators made it a top priority to reevaluate the regulations around cybersecurity and consumer data protection. In early 2016, the National Association of Insurance Commissioners (NAIC) began drafting the Insurance Data Security Model Law, investing almost two years in extensive deliberations including input from state insurance regulators, consumer representatives, and the insurance industry. NAIC adopted the model law in October 2017. State adoption of the model law is critical to ensure state insurance regulators have the tools they need to better protect sensitive consumer information.

What the model law does

The model law requires insurers and other entities licensed by a state department of insurance to develop, implement, and maintain an information security program based on its risk assessment, and includes a requirement that a designated employee to be in charge of securing the information (Section 4). Requirements for compliance are phased in based on careful, ongoing risk assessment for internal and external threats. Insurers are required to investigate a cyber security event (Section 5), and notify the state insurance commissioner of a cybersecurity event (Section 6). The model law also provides state insurance regulators the authority to remedy data security deficiencies they find during an examination. The model law exempts licensees with fewer than 10 employees, licensees compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and agents for a licensee from Section 4 of the model. It does not create a private cause of action, nor does it limit an already-existing private right of action.

Summary

Protecting consumer PII and other sensitive data is a high priority for insurance regulators in the wake of several major insurer data breaches.

The NAIC Insurance Data Security Model Law (#668) seeks to establish data security standards for regulators and insurers in order to mitigate the potential damage of a data breach. The law will apply to insurers, insurance agents, and other entities licensed by the state department of insurance.