BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: S-3995.1/14

ATTY/TYPIST: AL:lel

BRIEF DESCRIPTION: Concerning continuity of care for enrollees of the Washington health benefit exchange during grace periods.

AN ACT Relating to ensuring continuity of care for enrollees of the Washington health benefit exchange during grace periods; adding a new section 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.** The legislature finds that:

(1) The federal patient protection and affordable care act grants a ninety-day grace period to enrollees who receive an advance premium tax credit but fail to pay their premiums;

(2) For the first month of the grace period, the federal patient protection and affordable care act requires that an issuer of a qualified health plan pay physicians and other health care providers for services rendered to enrollees, but for the second and third months of the grace period, the issuer may pend claims for services rendered;

(3) If the enrollee fails to pay his or her outstanding premium before the end of the grace period, the issuer of a qualified health plan may deny the claim or claims for services rendered to the enrollee during the second and third months of the grace period;

(4) If an issuer of a qualified health plan denies the claim or

claims for services rendered, it creates a financial burden on physicians and other health care providers, as well as a disincentive for participating in the Washington health benefit exchange; and

(5) When a patient enters into the second and third months of the grace period, the federal patient protection and affordable care act requires that an issuer of a qualified health plan notify the enrollee's physician or other health care provider, but the notification requirement is vague and does not indicate when the issuer must provide the notification.

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

(1) An issuer of a qualified health plan shall pay a claim for any services provided to an enrollee during the full duration of the contract, including the grace period.

(2)(a) An issuer of a qualified health plan shall provide a notice to a health care provider or health care facility that an enrollee is in a grace period if the health care provider or health care facility:

(i)(A) Submits a request to the issuer regarding the enrollee's eligibility, coverage, or health plan benefits;

(B) Submits a request to the issuer regarding the status of a claim for services provided to an enrollee; or

(C) Reports a claim in a remittance advice; and

(ii) Request or claim is for a date during the second or third month of the enrollee's grace period.

(b) No later than seventy-two hours after receiving the request or claim under (a) of this subsection, the issuer of a qualified health plan shall provide the notice to the health care provider or health care facility through the same medium in which the health care provider or health care facility submitted the request or reported the claim. The notice to the health care provider or health care facility must include:

(i) The purpose of the notice;

(ii) The enrollee's full legal name and any unique numbers identifying the enrollee;

(iii) The name of the qualified health plan and the issuer;

(iv) The qualified health plan's unique health plan identifier; and

(v) The date on which the grace period for the enrollee began and the date on which the grace period will expire.

(3) A person injured by a violation of this section may seek injunctive relief in a court of competent jurisdiction.

(4) The provisions of this section cannot be waived by contract, and any contractual arrangements in conflict with the provisions of this section or that purport to waive any requirements of this section are null and void.

(5) For purposes of this section "grace period" means a period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year.

NEW SECTION. **Sec. 3.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

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