SENATE BILL REPORT
ESSB 6016

As Amended by House, March 5, 2014

Title: An act relating to the grace period for enrollees of the Washington health benefit exchange.

Brief Description: Concerning the grace period for enrollees of the Washington health benefit exchange.

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Rivers, Keiser, Cleveland, Tom, Kline and McAuliffe).

Brief History:
Committee Activity: Health Care: 1/30/14, 2/06/14 [DPS].
Passed Senate: 2/13/14, 48-0.
Passed House: 3/05/14, 92-6.

SENATE COMMITTEE ON HEALTH CARE

Majority Report: That Substitute Senate Bill No. 6016 be substituted therefor, and the substitute bill do pass.

Signed by Senators Becker, Chair; Dammeier, Vice Chair; Pedersen, Ranking Member; Angel, Bailey, Cleveland, Keiser and Parlette.

Staff: Mich'l Needham (786-7442)

Background: The federal Affordable Care Act regulations provide a 90-day grace period to enrollees in Exchange qualified health plans who receive an advance premium tax credit but fail to pay their premiums, if they have paid at least one full month's premium during the benefit year.

The first month of the grace period, the health insurance carrier must pay all appropriate claims for services rendered, and may pend claims for services rendered to the enrollee in the second and third months of the grace period. The carriers must notify providers of the possibility for denied claims when the enrollee is in the second and third months of the grace period.

At the end of the grace period, the health insurance carrier must terminate the enrollee's coverage if the enrollee has not paid all out-standing premiums.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Summary of Engrossed Substitute Bill: The Exchange must provide electronic notification to the qualified health plan before the sixth of the month indicating an enrollee has not paid the premium.

A health insurance carrier offering a qualified health plan in the Exchange must provide notice to a health care provider or health care facility that an enrollee is in a grace period if the health provider or facility submits a request regarding the enrollee's eligibility, coverage, or health plan benefits; requests information on the status of a claim; reports a claim; and the request or claim is during the second or third month of the grace period. The notice to the health care provider or facility must include the purpose of the notice, the enrollee's legal name and unique identifying numbers, and the name of the health plan and the carrier.

The grace period is defined to mean three consecutive months if an enrollee receiving advance premium tax credits through the Exchange has previously paid at least one full month's premium, consistent with the federal regulation.

Appropriation: None.

Fiscal Note: Not requested.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Substitute as Heard in Committee: PRO: The grace period creates a gaping hole and we need to protect the interests of providers. All parties need to come together and work on a solution. Some will say the 90-day grace period is a consumer protection and others may say it is bad policy. It impacts providers and does not allow them to be reimbursed for claims. The notification requirements are an enhancement over the requirements in the regulation, with additional details. Insurance carriers are in a better position to manage the risk for the full 90 days. We are confident that states can go beyond the regulation and provide greater protections than the federal law. Doctors are legally bound to see their patients. Turning them away requires notification and special letters. Even if this is not the solution, we urge you to keep this bill moving so we can keep a discussion moving. It about the viability of the Exchange and making sure providers and facilities participate in the networks.

CON: This bill is in direct conflict with the federal regulations. In the rulemaking, the U.S. Department of Health and Human Services (HHS) contemplated alternatives for the grace period and the regulations are the compromise. We believe that HHS is the sole regulator of the grace period and that this regulation does not provide flexibility for states to create different standards, unlike many regulations that provide specific flexibility. The notification standards conflict with the federal standards and we are unsure how we could implement with the conflict. We understand the bind this puts providers in and we are open to searching for an equitable solution, but it is not viable to hold carriers responsible for the entire issue. The approach in this bill will impact the premium rates for everyone. We believe it is a broader discussion impacting all states and we need to look for other ideas and national approaches.

Persons Testifying: PRO: Senator Rivers, prime sponsor; Dr. Dale Reisner, Sean Graham, WA State Medical Assn.; Lisa Thatcher, WA State Hospital Assn.

CON: Chris Bandoli, Regence BlueShield; Sydney Zvara, Assn. of WA Healthcare Plans; Sheela Tallman, Premera Blue Cross; Scott Plack, Group Health; Mel Sorensen, America's Health Insurance Plans.

House Amendment(s):

- Requires the Health Benefit Exchange to support the grace period by providing electronic information to issuers of qualified health and dental plans that complies with federal rules on termination of coverage.
- If the Exchange notifies an enrollee of a delinquency in paying premiums, the notice must include information on how to report a change in income or circumstances, as well as an explanation that such a report may result in a change in the premium amount or program eligibility.
- Modifies the requirement that an issuer notify a provider or facility that an enrollee is in a grace period as follows: (1) with respect to an enrollee in the second or third month of the grace period, requires the issuer to, upon request by a provider or facility, provide information regarding the enrollee's eligibility status in real-time, and notify a provider or facility that the enrollee is in the grace period within three business days after submittal of a claim or status request for services provided; and (2) requires the information or notification to, at a minimum, indicate "grace period" or a national coding standard as the reason for pending the claim if a claim is pended due to the grace period.
- Requires an annual report to the Legislature by the Exchange with the number of enrollees who entered the grace period; the number of enrollees who paid premium after entering the grace period; the average number of days enrollees were in the grace period prior to paying premium; and the number of enrollees who were in the grace period and whose coverage was terminated due to nonpayment of premium.
- If the Exchange report indicates that coverage was terminated due to nonpayment of premium for 10,000 or more enrollees who were in the grace period, the issuer's notification to the provider or facility must also indicate whether the enrollee is in the second or third month of the grace period, unless the notification is provided electronically. Makes this requirement effective January 1 following issuance of the report, but in no case before January 1, 2015. Requires the Exchange to notify affected parties and the Legislature if the contingency occurs.
- Defines grace period to mean nonpayment of premiums by an enrollee receiving advance payments of the premium tax credit as defined by the Affordable Care Act, and implementing regulations issued by the U.S. Department of Health and Human Services.