# HOUSE BILL REPORT
# HB 1626

**As Passed House:**
March 2, 2015

**Title**: An act relating to health benefit plan grace periods.

**Brief Description**: Addressing health benefit plan grace periods.

**Sponsors**: Representative Schmick.

**Brief History:**
**Committee Activity:**
Health Care & Wellness: 2/3/15, 2/13/15 [DP].
**Floor Activity:**
Passed House: 3/2/15, 87-10.

**Brief Summary of Bill**

- Permits a health care provider to choose whether to provide care to a qualified health plan enrollee in the second or third month of the grace period.

## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report**: Do pass. Signed by 15 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Jinkins, Johnson, Moeller, Robinson, Rodne, Short, Tharinger and Van De Wege.

**Staff**: Alexa Silver (786-7190).

**Background**:

Qualified Health Plan Grace Period.

Under the Affordable Care Act, an individual who enrolls in a qualified health plan through a health benefit exchange may be eligible for a premium tax credit if his or her household income is 100 to 400 percent of the poverty line and he or she is not eligible for minimum

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essential coverage. Individuals who are eligible for the premium tax credit may have the credit paid in advance directly to the issuer to lower their premiums.

Federal rules require an issuer of a qualified health plan to provide a grace 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. During the grace period, the issuer must pay all appropriate claims for services rendered during the first month, but may pend claims for services rendered during the second or third month. The issuer is required to notify the enrollee that he or she is delinquent on payment of the premium, notify the U.S. Department of Health and Human Services of the enrollee's non-payment, and notify providers of the possibility for denied claims when the enrollee is in the second or third month of the grace period. As the premium aggregator, the Washington Health Benefit Exchange (Exchange) has assumed the function of providing delinquency notices to enrollees.

If the enrollee exhausts the grace period without paying all outstanding premiums, the issuer must terminate his or her coverage effective the last day of the first month of the grace period.

In Washington, for an enrollee who is in the second or third month of the grace period, the issuer must: (1) provide real-time information regarding the enrollee's eligibility status upon request by a health care provider or facility; and (2) notify a health care provider or facility that an enrollee is in the grace period within three business days after submittal of a claim or status request for services provided. The information must indicate "grace period" or an appropriate national coding standard as the reason for pending the claim if the claim is pended due to the enrollee's grace period status. Unless the notification is sent electronically, it must indicate that the enrollee is in the second or third month of the grace period.

Charity Care.

Washington's charity care law prohibits a hospital or its medical staff from adopting or maintaining admission practices or policies that result in:

- a significant reduction in the proportion of patients who do not have third-party coverage and are unable to pay for hospital services;
- a significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is likely to be less than the anticipated cost or charge; or
- the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital.

**Summary of Bill**:

A health care provider may choose whether to provide care to a qualified health plan enrollee in the second or third month of the grace period, except as required by the charity care law.

The bill does not modify any rights in an agreement in existence on the bill's effective date.

**Appropriation**: None.

**Fiscal Note**: Not requested.

**Effective Date**: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

**Staff Summary of Public Testimony**:

(In support) This bill is based on a waiver that California received from the Centers for Medicare and Medicaid Services. It gives doctors the choice whether to grant care to a person who has not paid their bill.

(With concerns) It is the bedrock foundation of the health care coverage system that as long as you have insurance coverage and an insurance card, you should be able to access services. Health plans have concerns about whether this bill might invalidate contracts between carriers and providers. The bill provides that nothing impairs an existing agreement, but the effect is exactly to impair existing agreements. Health maintenance organizations and health care service contractors deliver care almost exclusively pursuant to participating provider agreements, which must comply with statutory standards. The covered individual has a right to services from participating providers. Statutes on participating providers should be amended to indicate that this is one activity to which normal consumer rights do not apply.

The scope of the problem for the provider community is unknown. The Exchange prepares annual reports on the number of terminations, but those reports do not gather information on where terminated members go. Premium aggregation has been the major cause of premium payment recording problems, and once the Exchange exits the premium-aggregation business, it is likely that operations will improve. It would be prudent to wait until after the Exchange stops premium aggregation to determine the ongoing impact on the provider community. There is no evidence that providers are dropping out of the Exchange network because of issues related to bad debt or the grace period. Providers may choose not to participate in a network without jeopardizing their contractual status with other lines of business.

The patient has coverage throughout the grace period, and the physician does his or her part by providing care, so the issuer should do its part by providing reimbursement. Having an insurance card also implies that there will be some form of reimbursement. This has been a source of consternation and financial loss for quite a few providers. Some have indicated that they are less willing to participate in Exchange products going forward. There is a decent grasp on the scope of the grace period problem; the Exchange report indicated that half of subsidized enrollees entered the grace period, and of those 7 percent had coverage terminated due to nonpayment of premium. Of those enrollees whose coverage was terminated, about one-third found other coverage, one-third went onto Medicaid, and one-third lost insurance coverage.

(Opposed) None.

**Persons Testifying**: (In support) Representative Schmick, prime sponsor.

(With concerns) Sydney Smith Zvara, Association of Washington Healthcare Plans; Len Sorrin, Premera Blue Cross; Chris Bandoli, Regence Blue Shield; Mel Sorensen, America's Health Insurance Plans; and Sean Graham, Washington State Medical Association.

**Persons Signed In To Testify But Not Testifying**: None.