SENATE BILL REPORT
HB 1626

As of March 20, 2015

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

Brief Description: Addressing health benefit plan grace periods.

Sponsors: Representative Schmick.

Brief History: Passed House: 3/02/15, 87-10.
Committee Activity: Health Care: 3/12/15.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: 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 the individual's household income is 100 to 400 percent of the poverty line and the individual is not eligible for minimum 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.

If the enrollee exhausts the grace period without paying all outstanding premiums, the issuer must terminate the 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.

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

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.

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

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: PRO: This provides a choice for providers to provide care; or not, knowing that they may not be reimbursed. This is modeled after California where it appears to be working. This is not our preferred approach. We would prefer the approach outlined in Senator Rivers' bill where carriers honor coverage for the full grace period. This would facilitate a conversation between providers and patients. Providers still retain their legal and ethical requirements to treat patients. This is a compromise we can live with.

CON: We oppose this because it is unnecessary and it does not change the provider's ethical responsibility to provide continuing care. It does nothing for clients in their second and third months of the grace period. We would like to see an amendment that provides stronger consumer protection with better notification to the client of the real consequences of going into the second and third months of the grace period. This is detrimental to consumers since they will lose access to care. This is different from California where they worked with the Centers for Medicare and Medicaid Services to address their approach, and where they suspended coverage in the second and third months. Subsidized people will lose access to care and we think this discriminates against low-income enrollees. We have network adequacy requirements and this bill raises concerns about potential impacts to the network adequacy if providers turn away patients. It also raises potential liability concerns if the provider turns a patient away and the medical issue becomes more serious in the following weeks. Health plans deliver services through participating providers that all sign agreements that encompass requirements in the insurance code that include duties to provide services even if a health plan becomes insolvent. We offer plans in the Exchange and Apple Health to serve the lower-income enrollees. Many individuals are new to insurance and not used to the payment requirements. This population is different and they do need the extra protections provided by the federal law.

Persons Testifying: PRO: Representative Schmick, prime sponsor; Sean Graham, WA State Medical Assn.

CON: Sarah Kwiatkowski, NW Health Law Advocates; Sydney Smith Zvara, Assn. of WA Healthcare Plans; Chris Bandoli, Regence; Andrea Tull, Coordinated Care; Mel Sorenson, America's Health Insurance Plans; Sheela Tallman, Premera Blue Cross.

Persons Signed in to Testify But Not Testifying: No one.