SENATE BILL REPORT
SB 5340

As of February 3, 2015

Title: An act relating to qualified health plan claims in grace periods.

Brief Description: Concerning qualified health plan claims in grace periods.

Sponsors: Senators Rivers, Keiser, Cleveland and McAuliffe.

Brief History:
Committee Activity: Health Care: 2/02/15.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Under the federal Affordable Care Act (ACA), an individual may enroll in a qualified health plan through the Health Benefit Exchange (Exchange), and an individual may be eligible for an advance premium tax credit to reduce the monthly premium. The ACA requires health insurance carriers to provide a 90-day grace period to an Exchange enrollee that received an advance premium tax credit but failed to pay the full premium, if the enrollee paid at least one full month's premium during the benefit year.

The federal regulations require health insurance carriers to pay all appropriate claims for services rendered during the first month of the grace period, and carriers 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 carrier must terminate the enrollee's coverage if the enrollee has not paid all outstanding premiums.

The 2014 Legislature passed SB 6016 requiring insurance carriers to provide specific notifications to health care providers regarding an enrollee's eligibility status and the status of a grace period. The bill also requires the Exchange to provide electronic information on an enrollee's grace period to each insurance carrier, and to provide an annual report to the Legislature including the number of enrollees who entered the grace period, the number of enrollees who subsequently paid the premium, the average number of days enrollees were in the grace period prior to paying the premiums, and the number of enrollees whose coverage was terminated due to nonpayment of premium.

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 Bill: By January 1, 2017, health insurance carriers issuing a qualified health plan in the Exchange must reimburse a health care provider or health care facility for all non-fraudulent claims for service provided to an enrollee during the grace period. Reimbursement may not be recouped due to enrollee non-payment of premiums.

The Exchange Board must ensure health insurance carriers follow the terms of a contract with a health care provider or health care facility that include reimbursing a health care provider or facility for non-fraudulent claims for services provided to an enrollee during the 90-day grace period.

Prior to terminating the coverage of an enrollee in a grace period, the Exchange must conduct outreach with the specific goal of ensuring that enrollees who are late in making premium payments are aware that they may be eligible for Medicaid coverage or for an increased subsidy level. Where possible, the outreach must include correspondence via mail, email, and telephone.

Appropriation: None.

Fiscal Note: Available.

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: We passed SB 6016 last year which ensured providers are notified of a patient in a grace period but we did not address the payment. It is not fair to the providers that they are not paid since they need to stay in business. Since last year's bill, we have information indicating 10,000 enrollees exhausted their grace period and were terminated from coverage. Providers have some significant losses for services that they have not been paid for. Providers are not risk-bearing entities like insurance carriers. The patient's welfare comes above all else and when a patient is receiving continued treatment. I cannot abandon the patient when they lose insurance. Providers may find it unacceptable to participate in the Exchange plans which will decrease access to care for patients.

CON: Last session we worked on the compromise language that resulted in notification. This language is in direct conflict with federal regulations and results in a very different approach from the rest of the private market. The federal regulations strike the right balance with carriers and providers. The federal standard is longer than other private coverage where we generally provide 30-37 days prior to cancellation of coverage with no payment for past services. The U.S. Department of Health and Human Services is the sole regulator of the grace period, they did not leave flexibility for the states. The additional expense of covering claims for the 90 days would impact premiums and the plans would be more expensive.

OTHER: The Exchange Board would be required to add certification criteria to ensure adherence to contracts and we do not have access to the contracts and reimbursement agreements today. It also requires additional outreach efforts that may be in conflict with the removal of premium aggregation since the Exchange will not have information on the premium payment status when it goes directly to the carriers.

Persons Testifying: PRO: Senator Rivers, prime sponsor; Sean Graham, WA State Medical Assn.; Dr. Kenneth Berger, WA State Urology Society.

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

OTHER: Joan Altman, WA Health Benefit Exchange.