FINAL BILL REPORT
SHB 2554

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Synopsis as Enacted

Brief Description: Mitigating inequity in the health insurance market caused by health plans that exclude certain mandated benefits.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Stonier, Cody, Macri, Riccelli, Robinson, Tharinger, Senn, Peterson, Valdez, Davis, Doglio, Dolan, Fitzgibbon, Walen, Frame, Ramel, Pollet, Ryu, Goodman, Lekanoff, Ormsby and Chapman).

House Committee on Health Care & Wellness
House Committee on Appropriations
Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means

Background:

Health carriers are required to offer health plans that include certain benefits mandated by state and federal law. For example, the federal Patient Protection and Affordable Care Act (ACA) requires individual and small group market health plans to offer a package of benefits known as the essential health benefits. State law also includes mandated health benefits not required under the ACA. For example, state law requires health plans that include maternity care coverage to also provide abortion coverage.

Health carriers are permitted under state and federal law to exclude certain mandated benefits. For example, health carriers are allowed to offer dental-only or vision-only coverage. Also, a religiously sponsored health carrier is not required to participate in the provision of, or payment for, a specific service if it objects to doing so by reason of conscience or religion.

A religiously sponsored health carrier that does not participate in the provision or payment of services on the basis of conscience or religion must:
- provide enrollees written notice of the services the carrier refuses to cover for reason of conscience or religion;
- provide written information describing how an enrollee may directly access services in an expeditious manner; and

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- ensure that enrollees who are refused services have prompt access to information describing how they may directly access services in an expeditious manner.

The Insurance Commissioner (Commissioner) must establish a mechanism to recognize the right of conscience or religion while ensuring enrollees timely access to services and to ensure prompt payment to providers. Under rules adopted by the Commissioner, all carriers are required to file a description of the process they will use to recognize an organization's or individual's exercise of conscience or religion when purchasing coverage; the process may not affect a nonobjecting enrollee's access to coverage for those services. A religiously sponsored health carrier that elects not to cover certain benefits because of religious beliefs must file a description of the process by which its enrollees will have timely access.

Summary:

A health carrier that excludes, under state or federal law, any mandated health benefit from any health plan or student health plan must notify each enrollee of which benefits are excluded and alternate ways in which the enrollee may access excluded benefits in a timely manner. Enrollees must have prompt access to this information and the carrier must clearly and legibly include the information in any of its marketing materials that include a list of benefits covered under the plan. The information must also be listed in the benefit booklet and posted on the carrier's health plan or student health plan website.

Beginning November 1, 2021, the Health Benefit Exchange (Exchange) must provide individuals seeking to enroll in coverage on its website with access to the information that carriers must provide when they exclude mandated benefits. The Exchange must provide this access directly on its website, through a link to an external site, or in any manner that allows consumers to easily access the information. Beginning July 1, 2021, the Insurance Commissioner (Commissioner) must post on his or her website information on carrier requirements and alternate ways in which enrollees may access excluded benefits in a timely manner.

For the stated purpose of mitigating inequity in the health insurance market, the Commissioner must assess a fee on any health carrier offering a health plan or student health plan if the health plan or student health plan excludes, under state or federal law, any essential health benefit or benefit that is required under state law or rule. The Commissioner must set the fee in an amount that is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit. A health carrier subject to the fee must submit, as part of its rate filing, an estimate of the amount of the fee and supporting documents for the estimate. The supporting documents must include a certification by a member of the American Academy of Actuaries that the estimated fee is the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit. The fee must be deposited into the General Fund.

The Commissioner may waive the fee if he or she finds the carrier had provided alternate access to the excluded benefits in a timely manner.

Votes on Final Passage:

House	59	39	
Senate	28	21	(Senate amended)
House	58	39	(House concurred)

Effective: June 11, 2020