HOUSE BILL REPORT
SHB 2554

As Amended by the Senate

Title: An act relating to mitigating inequity in the health insurance market caused by health plans that exclude certain mandated benefits.

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).

Brief History:
Committee Activity:
Health Care & Wellness: 1/29/20, 2/5/20 [DPS];
Appropriations: 2/8/20, 2/10/20 [DPS(HCW)].
Floor Activity:
Passed House: 2/17/20, 59-39.
Senate Amended.
Passed Senate: 3/5/20, 28-21.

Brief Summary of Substitute Bill

- Requires health carriers and the Health Benefit Exchange to provide certain notices to consumers when mandatory benefits are excluded from health plans.
- Allows the Insurance Commissioner to assess a fee on a health carrier that excludes certain mandatory benefits.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 9 members: Representatives Cody, Chair; Macri, Vice Chair; Chopp, Davis, Riccelli, Robinson, Stonier, Thai and Tharinger.

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.

Minority Report: Do not pass. Signed by 4 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers and DeBolt.

Minority Report: Without recommendation. Signed by 1 member: Representative Harris.

Staff: Jim Morishima (786-7191).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 19 members: Representatives Ormsby, Chair; Robinson, 1st Vice Chair; Bergquist, 2nd Vice Chair; Chopp, Cody, Dolan, Fitzgibbon, Hansen, Hudgins, Kilduff, Macri, Pettigrew, Pollet, Ryu, Senn, Springer, Sullivan, Tarleton and Tharinger.

Minority Report: Do not pass. Signed by 13 members: Representatives Stokesbary, Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Corry, Dye, Hoff, Kraft, Mosbrucker, Schmick, Steele, Sutherland and Ybarra.

Staff: Meghan Morris (786-7119).

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

The Office of the Insurance Commissioner (OIC) must establish a mechanism to recognize the right of conscience while ensuring enrollees timely access to services and to ensure prompt payment to providers. Under rules adopted by the OIC, 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 when purchasing coverage; the process may not affect a nonobjecting enrollee's access to coverage for those services. A religiously sponsored 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 of Substitute Bill:

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.

For the stated purpose of mitigating inequity in the health insurance market, the Insurance Commissioner (Commissioner) may 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.

EFFECT OF SENATE AMENDMENT(S):

The Senate amendment requires, rather than permits, the fee; allows the Insurance Commissioner (Commissioner) to waive the fee if he or she finds the carrier has provided alternate access to the excluded benefits in a timely manner; and requires the Commissioner, beginning July 1, 2021, to post information on his or her website on carrier requirements and alternate ways in which enrollees may access excluded benefits in a timely manner.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) This bill is about protecting consumers' access to services. When consumers buy a health plan, they should know whether all mandated services are covered in order to make informed decisions. This bill is also about fairness in the insurance market, since a plan that refuses to cover certain benefits will be competing in the market alongside plans that offer the benefit. Consumers already face enough barriers to access. Finding, keeping, and dealing with insurance can be terrifying. When services are excluded, there should be a way for consumers to get information that is upfront and transparent. The burden should not be solely on the consumer to fill the gaps by finding the services and covering the costs. These are gaps that have life-changing consequences, especially for young people trying to deal with their futures.

Consumers must know how to access urgent services, especially in emergencies. The provisions of this bill requiring the Health Benefit Exchange to provide information to consumers are insufficient. The Office of the Insurance Commissioner or another state agency should provide the information. Providing the information on a state website will ensure it is readily available at all times, not just at the time of enrollment or renewal.

(Opposed) None.

Staff Summary of Public Testimony (Appropriations):

(In support) This legislation does two very important things in the insurance market. First, it ensures enrollees have access to the same benefits as the rest of the state. Second, it ensures equity in the health insurance marketplace among the providers of these plans. If an insurer chooses to exercise their conscience by not offering a benefit while competing in a marketplace with other plans offering that same benefit, then that creates an unequal financial playing field. This bill is about fairness among plans and fairness for the consumers.

(Opposed) None.

Persons Testifying (Health Care & Wellness): Representative Stonier, prime sponsor; Lonnie Johns-Brown, Office of the Insurance Commissioner; Emily Murphy and Kathryn Karcher, NARAL Pro-Choice Washington; and Steve Breaux, Planned Parenthood Votes.

Persons Testifying (Appropriations): Lonnie Johns-Brown, Office of the Insurance Commissioner.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.