SENATE BILL REPORT
SHB 2554

As Reported by Senate Committee On:
Health & Long Term Care, February 24, 2020
Ways & Means, February 28, 2020

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: Passed House: 2/17/20, 59-39.
Committee Activity: Health & Long Term Care: 2/21/20, 2/24/20 [DPA-WM, DNP].
Ways & Means: 2/28/20 [DPA (HLTC), DNP].

Brief Summary of Amended 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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Randall, Vice Chair; Conway, Dhingra, Frockt, Keiser and Van De Wege.

Minority Report: Do not pass.
Signed by Senators O'Ban, Ranking Member; Becker, Muzzall and Rivers.

Staff: Evan Klein (786-7483)

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.

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Billig, Carlyle, Conway, Darneille, Dhingra, Hasegawa, Hunt, Keiser, Pedersen and Van De Wege.

Minority Report: Do not pass.

Signed by Senators Braun, Ranking Member; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant Ranking Member, Capital; Becker, Muzzall, Rivers, Schoesler, Wagoner, Warnick and Wilson, L..

Staff: Sandy Stith (786-7710)

Background: Health carriers must offer health plans that include certain benefits mandated by state and federal law. 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 includes mandated health benefits not required under the ACA, including a requirement that health plans including maternity care coverage 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 not participating 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 Amended 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 July 1, 2021, the OIC must post on its website written notice of the carrier notification requirements and information on alternate ways to access excluded benefits in a timely manner. Beginning November 1, 2021, the Health Benefit Exchange (Exchange) must provide individuals seeking to purchase 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 must assess a fee on any health carrier offering a health plan or student health plan if the plans exclude, 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 actuarially equivalent of costs attributed to the provision and administration of the excluded benefit. Carriers that exclude a mandated benefit must submit an estimate of the amount of the fee as part of its rate filing with the OIC. As part of the filing, the carrier must provide supporting documentation of its methods for estimating the fee, including 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. If the commissioner finds the carrier provides access to all excluded mandatory benefits, the fee may be waived. The fee collected must be deposited into the general fund.

EFFECT OF HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S): Requires, instead of permitting, the insurance commissioner to assess a fee on a health carrier that excludes certain mandatory health benefits. Permits the insurance commissioner to waive the fee on a health carrier if the commissioner finds the carrier provides alternative access to all excluded mandatory benefits. Requires the commissioner to provide information on its website, including alternate ways in which enrollees may access excluded benefits.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Substitute House Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: This bill is to bring equity to the marketplace. When carriers want to participate on the Exchange, they should be held to the same standard as all carriers on the Exchange. There is only a small challenge to overcome, which is to consider how information be provided to Washington residents from state agencies. This bill is about the fairness to

patients and fairness to other insurers in the marketplace. People buy insurance based on price. Patients may know a benefit is not covered and choose to purchase a plan based on the reduced price of that plan, if the plan does not have to pay for the benefit.

CON: This is a direct assault on conscience rights. Plans may morally object to provide certain benefits because of religious objection. The bill requires exempt carriers to be complicit with the very acts that they object to. It is not clear what is meant by the notification requirement, but it would be read to require an objecting organization to provide an enrollee with information about abortion services. A person cannot reasonably expect that an insurance carrier that they chose because it did not include a certain benefit, would provide that person with access to information about the benefit.

Persons Testifying (Health & Long Term Care): PRO: Representative Monica Jurado Stonier, Prime Sponsor; Lonnie Johns-Brown, Office of the Insurance Commissioner.

CON: Theresa Schrempp, citizen.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on Bill as Amended by Health & Long Term Care (Ways & Means): No public hearing held.

Persons Testifying (Ways & Means): No one.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.