SENATE BILL REPORT
SB 6400

As Reported by Senate Committee On:
Health & Long Term Care, February 5, 2020
Ways & Means, February 11, 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: Senators Randall, Cleveland, Keiser, Kuderer, Wilson, C., Hunt, Van De Wege, Dhingra, Das, Lovelett, Nguyen, Conway and Saldaña.

Brief History:
Committee Activity: Health & Long Term Care: 2/03/20, 2/05/20 [DPS-WM, DNP, w/ oRec].
Ways & Means: 2/10/20, 2/11/20 [DP2S, DNP].

Brief Summary of Second Substitute Bill

- Requires the insurance commissioner to assess a fee on a health carrier that excludes certain mandatory 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 benefits.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6400 be substituted therefor, and the substitute bill do pass 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.

Minority Report: That it be referred without recommendation.

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.

Signed by Senators Muzzall and Rivers.

Staff: Evan Klein (786-7483)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 6400 be substituted therefor, and the second substitute bill 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, Liias, 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 Bill (Second Substitute): 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 CHANGES MADE BY WAYS & MEANS COMMITTEE (Second Substitute):

- Requires 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.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Clarifies that a carrier must include specified information in any of its marketing materials that include a list of benefits covered under the plan, instead of in all of its marketing materials.

- Clarifies that the commissioner must set the fee on health carriers that is actuarially equivalent to any excluded benefits.
- Requires carriers that exclude a mandated benefit to submit to the commissioner an estimate of the amount of the fee as part of rate filing.
- Requires carriers to include in its supporting documentation 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.
- Requires the commissioner to provide information on its website, including alternate ways in which enrollees may access excluded benefits.
- Requires the exchange to provide individuals with certain information about excluded benefits beginning November 1, 2021, instead of July 1, 2021.
- Adds a severability clause.

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 Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: Every Washingtonian should have access to the comprehensive health care that they deserve. This is building on work done last session to ensure individuals have access to reproductive services in Washington. There is not much time to ensure individuals have access to comprehensive reproductive health care with plan offerings planned for 2021 that do not include all health plan benefits. If there is a mechanism that would prevent carriers from passing along the costs of paying for these services to their enrollees, then there is a desire to work on additional language. The hope is to develop mechanisms to protect individuals and ensure that they are receiving information about what services are covered by a plan in as many ways as possible. This bill is critical for consumer protection and market fairness. Individuals are already required to pay for these services in their premiums, since they are state required services. It is not fair to permit these carriers to not pay for these services. It should be made crystal clear, up front, when an individual looks to purchase an insurance plan, what benefits the plan excludes. This bill would capture any state required service that a plan chooses not to cover. It is important to ensure enrollees have timely access to information. There is hope that the bill could also be expanded to require OIC or another state agency to make information available to enrollees on how to access services.

Persons Testifying (Health & Long Term Care): PRO: Senator Emily Randall, Prime Sponsor; Emily Murphy, NARAL Pro-Choice Washington.

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

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: This bill is critical

for consumer protection. The state should not have to absorb costs for mandatory benefits. Consumers should have a clear understanding about what they are buying when they purchase health coverage. Health plans should be transparent about what benefits they offer and exclude. Consumers need access to the same benefits that all other consumers have. This is a fairness and equity issue. By some carriers not providing all mandated benefits, this also creates financial inequities between plans. We would like to make sure there is consistency and continuity in the bill language. We have provided suggestions to clarify the bill language.

Persons Testifying (Ways & Means): PRO: Emily Murphy, NARAL Pro-Choice Washington; Lonnie Johns-Brown, Office of the Insurance Commissioner; Steve Breaux, Planned Parenthood Votest NW & Hawaii.

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