HOUSE BILL REPORT
ESSB 6016

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to the grace period for enrollees of the Washington health benefit exchange.

Brief Description: Concerning the grace period for enrollees of the Washington health benefit exchange.

Sponsors: Senate Committee on Health Care (originally sponsored by Senators Rivers, Keiser, Cleveland, Tom, Kline and McAuliffe).

Brief History:
Committee Activity:
Health Care & Wellness: 2/24/14, 2/26/14 [DPA].

Brief Summary of Engrossed Substitute Bill
(As Amended by Committee)

- Requires an issuer of a qualified health plan to provide information to health care providers and facilities regarding enrollees who are in the second or third month of the grace period.
- Requires the Health Benefit Exchange to notify a qualified health plan that an enrollee has not paid his or her premium and include certain information in a delinquency notice to an enrollee.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 16 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Clibborn, Green, G. Hunt, Jinkins, Manweller, Moeller, Morrell, Rodne, Ross, Short, Tharinger and Van De Wege.

Staff: Alexa Silver (786-7190).

Background:

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.

Under the Affordable Care Act (ACA), an individual who enrolls in a qualified health plan through a health benefit exchange may be eligible for a premium tax credit if his or her household income is 100 to 400 percent of the poverty line and he or she is not eligible for minimum essential coverage (*e.g.*, through Medicaid or an employer-sponsored plan). Individuals who are eligible for the premium tax credit may have the credit paid in advance directly to the issuer to lower their premiums.

Federal rules require an issuer of a qualified health plan to provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the issuer must pay all appropriate claims for services rendered during the first month, but may pend claims for services rendered during the second or third month. The issuer is required to notify the enrollee that he or she is delinquent on payment of the premium, notify the U.S. Department of Health and Human Services of the enrollee's non-payment, and notify providers of the possibility for denied claims when the enrollee is in the second or third month of the grace period. As the premium aggregator, the Washington Health Benefit Exchange (Exchange) has assumed the function of providing delinquency notices to enrollees.

If the enrollee exhausts the grace period without paying all outstanding premiums, the issuer must terminate his or her coverage effective the last day of the first month of the grace period.

The ACA provides that it does not preempt state law that "does not prevent the application of" the provisions of the ACA.

Summary of Amended Bill:

With respect to an enrollee in the second or third month of the grace period, an issuer of a qualified health plan must:

- upon request by a health care provider or health care facility, provide information regarding the enrollee's eligibility status in real time; and
- notify a provider or facility that the enrollee is in the grace period within three business days after submittal of a claim or status request for services provided.

If a claim is pended due to the grace period, the information or notification must, at a minimum, indicate "grace period" or the appropriate national coding standard as the reason for pending the claim.

By December 1, 2014, and annually each December 1 thereafter, the Exchange must submit a report to the Legislature with the following information for the calendar year: the number of enrollees who entered the grace period; the number of enrollees who paid premium after entering the grace period; the average number of days enrollees were in the grace period prior to paying premium; and the number of enrollees who were in the grace period and whose coverage was terminated due to non-payment of premium.

If the Exchange report indicates that coverage was terminated due to non-payment of premium for 10,000 or more enrollees who were in the grace period, the issuer's notification to the provider or facility must also indicate whether the enrollee is in the second or third month of the grace period, unless the notification is provided electronically. This requirement is effective January 1 following issuance of the Exchange's report, but in no case before January 1, 2015. If the contingency occurs, the Exchange must notify affected parties, the Secretary of the Senate, the Chief Clerk of the House of Representatives, the Office of the Code Reviser, and others as deemed appropriate.

If the Exchange notifies an enrollee of a delinquency in paying premium, the notice must include information on how to report a change in income or circumstances, as well as an explanation that such a report may result in a change in the premium amount or program eligibility. The Exchange must provide electronic notification to a qualified health plan before the sixth of the month indicating that an enrollee has not paid his or her premium.

"Grace period" is defined as non-payment of premiums by an enrollee receiving advance payments of the premium tax credit, as defined by the ACA and implementing regulations issued by the U.S. Department of Health and Human Services.

Amended Bill Compared to Engrossed Substitute Bill:

The amended bill modifies the requirement that an issuer notify a provider or facility that an enrollee is in the grace period. It changes the circumstances under which the issuer must provide information to a provider or facility and requires the information to indicate "grace period" or a national coding standard. It adds the requirement that the Exchange submit an annual report to the Legislature. It requires the issuer's notification to include information about whether the enrollee is in the second or third month of the grace period contingent on the results of the Exchange's report to the Legislature.

The amended bill also requires certain information to be included in any delinquency notice that the Exchange provides to an enrollee.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 3, which takes effect if the Exchange issues a report indicating that coverage was terminated due to nonpayment of premium for 10,000 or more enrollees who were in the grace period in that calendar year.

Staff Summary of Public Testimony:

(In support) Physicians and facilities are requesting notification that a patient is in a grace period. This takes two forms: eligibility checks done in real time and a response from the qualified health plan after a claim is submitted. This information on eligibility status would

be provided within a timeframe that makes sense. This version of the bill reaches a reasonable solution. Federal requirements are insufficient, because they do not say who to notify or when to provide notification. A report from the Exchange on the number of enrollees who did not pay premium and the number who subsequently paid will help show how big of a problem this is.

The notice required in this bill will allow for coordination of care between a patient and a physician. It will help ensure that providers are willing to participate in Exchange plans. A physician has a moral, ethical, and legal obligation to provide care, and this bill is not about creating an opportunity for a physician to drop a patient. It is also not about reimbursement.

(In support with amendments) The details about notification matter greatly. The uncertainty about federal guidance is of great concern. The Legislature should leave the broadest latitude to have a standard that complies with whatever the federal government may put forward, rather than develop a series of requirements that may differ from federal guidance. Implementing these changes will require costly programming and administrative changes.

(With concerns) This bill has been improved, but is still a work in progress. The requirements should be consistent with federal guidelines, because the federal government is still contemplating this issue. System changes will be costly. There is a concern about the requirement to include specific pend codes, because those are still being developed, and it is unclear what level of specificity they will provide. There are also concerns about some of the details of the information being shared between the provider and the plan regarding eligibility and claims status. For some transactions, carriers are unable to indicate the month of the grace period. If a consumer reports a change in income, the premium may drop. Consumer protection language should be added to the bill.

(Opposed) Because no enrollee has hit the date by which a notice would be issued, it is unknown whether the notification provisions in federal guidance are insufficient. The federal government may issue additional language or guidance, and there is concern about doing something that is immediately in conflict with federal rules. The notification provisions go beyond what the federal guidance requires. The bill should be amended to give the state authority to ensure that carriers are following the federal guidance. Legislation could be introduced next year after the study provides information about the scope of the problem.

Persons Testifying: (In support) Sean Graham, Washington State Medical Association; Lisa Thatcher, Washington State Hospital Association; and Scott Plack, Group Health Cooperative.

(In support with amendments) Mel Sorensen, American Health Insurance Plans.

(With concerns) Sheela Tallman, Premera Blue Cross; Sydney Smith Zvara, Association of Washington Healthcare Plans; and Sarah Kwaitkowski, Northwest Health Law Advocates.

(Opposed) Chris Bandoli, Regence Blue Shield.

Persons Signed In To Testify But Not Testifying: None.