SENATE BILL REPORT
SB 5805

As Reported by Senate Committee On:
Health & Long Term Care, February 19, 2019

Title: An act relating to making state law consistent with selected federal consumer protections in the patient protection and affordable care act.

Brief Description: Making state law consistent with selected federal consumer protections in the patient protection and affordable care act.

Sponsors: Senators Cleveland, Wellman, Randall, Billig, Nguyen, Pedersen, Saldaña, Carlyle, Kuderer, Wilson, C., Conway, Darneille, Hasegawa, Takko, Keiser, Frockt, Hunt, Mullet, Rolfes, McCoy, Salomon, Van De Wege, Das, Liias, Hobbs, Palumbo and Dhingra.

Brief History:
Committee Activity: Health & Long Term Care: 2/18/19, 2/19/19 [DPS, DNP, w/oRec].

Brief Summary of First Substitute Bill

- Codifies various provisions included in the Patient Protection and Affordable Care Act into state law.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5805 be substituted therefor, and the substitute bill do pass.
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; Bailey and Becker.

Minority Report: That it be referred without recommendation.
Signed by Senator 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.

Background: Patient Protection and Affordable Care Act. The Affordable Care Act (ACA) was passed in 2010, which created the option for states to expand Medicaid, established health insurance exchanges, required most individuals to have health insurance, created penalties for certain large employers who did not offer affordable coverage to their employees, and enacted other requirements relating to medical loss ratios, guaranteed issue, renewability of coverage, and non-discrimination standards.

Essential Health Benefits. The ACA requires non-grandfathered individual and small group market health plans to offer ten essential health benefits (EHB) categories both inside and outside of the Health Benefit Exchange. States establish the essential health benefits using a supplemented benchmark plan.

Community Rating. The ACA prohibits variation in rates for a given plan except based on four factors. The Insurance Commissioner (Commissioner), using an analysis of various health status, claims, and utilization factors, sets the geographic rating areas and permissible age bands.

Guaranteed Issue. The ACA requires health plans to permit individuals to enroll in the plan regardless of health status, age, gender, or other factors that might predict the use of health services. The ACA also prohibits the extent of coverage offered to an individual from being limited due to the individual's health status.

Prohibition on Unfair Rescissions. The ACA prohibits group and individual health plans from rescinding coverage once an individual is covered under the plan, unless the individual performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact.

Cost-sharing. The ACA establishes a limit on the out-of-pocket expenses an individual can be required to pay for coverage of EHBs. The ACA sets separate total limits for individual coverage and family coverage, but requires the out-of-pocket limit for individual coverage be applied to each individual covered under a family plan as well.

Lifetime Limits. The ACA prohibits health plans from putting annual or lifetime dollar limits on most benefits received by health plan enrollees.

Medical Loss Ratio. The ACA limits the portion of premium dollars health insurers may spend on administration, marketing, and profits. Health insurers must publicly report in each state in which they operate, the portion of premium dollars spent on health care, quality improvement, and other activities. Health insurers that cover individuals and small businesses must spend at least 80 percent of premiums on health care claims and quality improvement, whereas insurers that cover large group plans must spend at least 85 percent of premiums on health care claims and quality improvement. If insurers fail to meet the medical loss ratio standard, the insurer must provide rebates to enrollees.

Explanation of Coverage. The ACA requires insurers and group health plans to provide a summary of benefits and coverage (SBC) to consumers. The SBC must include 12 different content elements; they must be provided to consumers enrolling in a health plan, newly

eligible to enroll in a plan, during a special enrollment, whenever coverage changes or is modified, and upon request.

Waiting Periods. The ACA prohibits group health plans and group health insurance issuers from applying any waiting period that exceeds 90 days. A waiting period is defined as the period of time that must pass before coverage becomes effective for an enrollee or dependent who is otherwise eligible to enroll in a plan.

Summary of Bill (First Substitute): Essential Health Benefits. EHB categories are defined as:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

The benchmark plan selected by the commissioner for the individual and small group market must include all ten of the essential health benefits categories as defined in Washington, as opposed to as specified by the ACA.

Guaranteed Issue and Eligibility. Carriers are prohibited from rejecting an individual for a group or individual health plan based upon preexisting conditions of the individual and are prohibited from denying, excluding, or limiting coverage for an individual's preexisting health conditions, including through preexisting condition exclusions or waiting periods.

Health carriers and health plans may not establish rules for eligibility based on any of the following factors:

- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability, including conditions arising out of acts of domestic violence;
- disability; or
- any other health status-related factor determined appropriate by the commissioner.

Prohibiting Unfair Rescissions. Health carriers and health plans offering group or individual health coverage may not rescind coverage once an enrollee is covered under the plan, unless the enrollee performs an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the coverage.

Cost Sharing. For plan years beginning in 2020, the cost sharing incurred under a health plan for the essential health benefits may not exceed:

- for self-only coverage—the amount required under federal law for the calendar year; or if there are no cost-sharing requirements under federal law, $8,200 dollars increased by the premium adjustment percentage for the calendar year; and
- for coverage other than self-only coverage—the amount required under federal law for the calendar year; or if there are no cost-sharing requirements under federal law, $16,400 dollars increased by the premium adjustment percentage for the calendar year.

Regardless of whether an enrollee is covered by a self-only plan or a plan that is other than self-only, the enrollee's cost sharing for the essential health benefits may not exceed the self-only annual limitation on cost sharing.

Lifetime Limits. A health carrier is prohibited from imposing annual or lifetime dollar limits on an EHB, other than those permitted as reference-based limitations under rules adopted by the Commissioner.

Explanation of Coverage. The commissioner must develop standards for use by a health carrier offering individual and group coverage, to provide applicants and enrollees accurate summaries of benefits and coverage. The standards must ensure the summary of benefits and coverage:

- is presented in a uniform format, does not exceed four pages, and does not include print smaller than 12-point font;
- is presented in a culturally and linguistically appropriate manner; and
- includes:
    1. uniform definitions;
    2. a description of the coverage;
    3. the exceptions, reductions, and limitations of the coverage;
    4. cost-sharing provisions;
    5. the renewability of the coverage;
    6. examples of common benefits scenarios;
    7. a statement of whether the plan provides minimum essential coverage and ensures that the plan share of the total allowed costs of benefits is no less than 60 percent of the costs;
    8. a summary of the policy or certificate; and
    9. a contact number for the consumer to call with additional questions and a website where a copy of the coverage policy or certificate may be reviewed.

The commissioner must periodically review and update these standards.

Health carriers must provide summaries of benefits and coverage explanations to applicants, enrollees, and policyholders or certificate holders. Carriers must provide notice of a material modification of the terms of the plan no later than 60 days prior to the date the modification becomes effective.

Violations of the notification provisions subject a carrier to a fine of up to $1,000 for each failure.

Waiting Periods for Group Coverage. Group health plans may not apply any waiting periods that exceed 90 days.

Issuer and Health Plan Discrimination. Health carriers are prohibited from discriminating against individuals because of their age, disability, or expected length of life in making coverage decisions, determining reimbursement rates, and establishing incentive programs. Health carriers must ensure that essential health benefits are not subject to denial to individuals against their wishes on the basis of the individuals' age, expected length of life, present or predicted disability, degree of medical dependency, or quality of life.

Qualified health plans are prohibited from employing marketing practices or benefit designs that discourage enrollment in the plan by individuals with significant health needs.

Rulemaking. Unless preempted by federal law, the commissioner must adopt rules necessary to implement various provisions in the act consistent with federal rules and guidance in effect on January 1, 2017, implementing the ACA.

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

- Clarifies that the Essential health Benefits include rehabilitative and habilitative devices, as well as services.
- Removes the Parts pertaining to Modified Community Rating and Medical Loss Ratio.
- Prohibits health carriers from discriminating against individuals because of their age, disability, or expected length of life in making coverage decisions, determining reimbursement rates, and establishing incentive programs.
- Requires health carriers to ensure that essential health benefits are not subject to denial to individuals against their wishes on the basis of the individuals' age, expected length of life, present or predicted disability, degree of medical dependency, or quality of life.
- Prohibits qualified health plans from employing marketing practices or benefit designs that discourage enrollment in the plan by individuals with significant health needs.

Appropriation: None.

Fiscal Note: Not requested.

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: *The committee recommended a different version of the bill than what was heard.* PRO: The ACA allowed patients to purchase coverage and be protected from being denied coverage. This bill guarantees citizens of Washington that their health coverage is protected in the state regardless of the

state of the federal ACA. People who purchase insurance with preexisting conditions are afraid of what might happen to the ACA at the federal level, and whether their ability to access insurance will be protected. This bill will allow patients to rest assured that they are protected regardless of what happens with federal law. Lifetime caps and annual maximums can be exhausted quickly for individuals with expansive treatment needs, which can force individuals to change jobs and remain terrified that they may no longer be able to access care. The protections afforded by the ACA have allowed individuals to start small businesses and live their lives. Health insurance is very expensive, but the ACA at least protects individuals with preexisting conditions to afford coverage. Being denied or dropped from coverage force individuals to make sacrifices to afford the care they need.

OTHER: There is no objection to maintaining the consumer benefits in the bill. There is a note that the ACA made coverage more affordable because of the federal financial supports in the bill. The federal subsidies are not included in this bill, and if the ACA goes away, it may create expensive coverage mandates. There is also a technical concern related to the rate provisions in the bill. There is a hope that large group market plans be allowed to continue employer flexibility. There is also a need in section 22 to allow for federal explanation of benefits forms to meet the state requirement.

Persons Testifying: PRO: Senator Annette Cleveland, Prime Sponsor; Erin Dziedzic, Bleeding Disorder Foundation of Washington; Dwayne Whitis, Patient; Ken West, Patient; Claire Symons, Patient.

OTHER: Meg Jones, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: No one.