SENATE BILL REPORT
SHB 1870

As of March 15, 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: House Committee on Health Care & Wellness (originally sponsored by Representatives Davis, Cody, Ryu, Jinkins, Dolan, Senn, Bergquist, Peterson, Thai, Valdez, Morgan, Robinson, Goodman, Kilduff, Fey, Pollet, Appleton, Orwall, Mead, Kirby, Kloba, Gregerson, Fitzgibbon, Stanford and Tharinger).

Brief History: Passed House: 3/01/19, 56-38.
Committee Activity: Health & Long Term Care: 3/15/19.

Brief Summary of Bill

- Codifies certain provisions of the federal Patient Protection and Affordable Care Act.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Staff: Evan Klein (786-7483)

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.

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.

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.

Out-Of-Pocket Maximums. 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 placing annual or lifetime dollar limits on most benefits received by health plan 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.

Non-Discrimination. The ACA prohibits a health carrier from making coverage decisions, determining reimbursement amounts, establishing incentive programs, or designing benefits in a way that discriminates against individuals because of their age, disability, or life expectancy. Similarly, health carriers are required to ensure essential health benefits are not subject to denial based on age, life expectancy, disability, degree of medical dependency, or quality of life. Qualified health plans are prohibited from employing marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs.

State law prohibits discrimination in insurance transactions based on sex, marital status, sexual orientation, race, creed, color, national origin, or the presence of any sensory, mental, or physical disability, or the use of a trained dog guide or service animal. Health care service contractors are prohibited from discriminating on the basis of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Health maintenance organizations are prohibited from discriminating on the basis of any sensory, mental, or physical handicap. This does not prohibit a health care service contractor or health maintenance organization from limiting or denying coverage when a person does not meet essential eligibility requirements because of a medical condition.

Summary of Bill: Guaranteed Issue and Eligibility. A health carrier is prohibited from rejecting an applicant based on a pre-existing condition. Similarly, a health carrier may not deny, exclude, or otherwise limit coverage for an individual's pre-existing condition, including pre-existing condition exclusions or waiting periods. Provisions relating to pre-existing condition exclusions and waiting periods and the standard health questionnaire are eliminated or repealed.

A health carrier may not establish eligibility rules based on:

- health status;
- medical condition;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability;
- disability; or
- any other health status-related factor determined appropriate by the insurance commissioner (commissioner).

Open Enrollment Periods. The commissioner's requirement to establish open enrollment periods is expanded to include all persons, instead of only persons under the age of nineteen. The commissioner may levy fines against a carrier that refuses to sell guaranteed issue policies to any person, instead of only persons under the age of nineteen.

Rescissions. A health plan or health carrier may not rescind coverage for an enrollee once the enrollee is covered under the plan, except in situations involving fraud or material misrepresentation.

Essential Health Benefits. The ten essential health benefit categories are defined to include:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder treatment, including behavioral health treatment;
- 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.

References to federal law are eliminated in provisions relating to selecting and supplementing of the state benchmark plan.

Out-of-Pocket Maximums. For plan years beginning in 2020, the cost-sharing incurred under a health plan for the essential health benefits may not exceed the amount required under federal law for the calendar year. If there are no cost-sharing requirements under federal law, the cost sharing may not exceed $8,200 for self-only coverage and $16,400 for family

coverage, increased by the premium adjustment percentage for the calendar year. An enrollee's cost-sharing may not exceed the self-only limit regardless of whether he or she is enrolled in self-only or family coverage.

The premium adjustment percentage for the calendar year is the percentage, if any, by which the average per capita premium for health insurance in Washington for the previous year exceeds the average per capita premium for 2020 as determined by the commissioner.

Lifetime Limits. A health carrier may not impose annual or lifetime limits on an essential health benefit, other than those permitted as reference-based limitations under rules adopted by the commissioner.

Explanation of Coverage. A health carrier must provide a summary of benefits and coverage explanation (SBCE), either in paper or electronically, to:

- an applicant at the time of application;
- an enrollee prior to the time of enrollment or re-enrollment; and
- a policy holder or certificate holder at the time of issuance.

The commissioner must develop standards for health carriers to use when providing a SBCE to applicants, enrollees, and policyholders. The standards require the SBCE be presented in a uniform format of four pages or less in at least 12-point font, is culturally and linguistically appropriate, and uses terms understandable by the average enrollee, and includes:

- uniform definitions that allow consumers to compare coverage and understand the terms of coverage;
- a description of the coverage, reductions and exceptions on coverage, cost-sharing provisions, and renewability and continuation of coverage provisions;
- a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing;
- a statement of whether the plan provides minimum essential coverage under federal law and ensures the plan share of total allowed costs is no less than 60 percent of the costs;
- a statement that the outline is a summary and the coverage document itself should be consulted to determine the governing contractual provisions; and
- a contact number for the consumer to call with additional questions and a website where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

The commissioner must use the current federal SBCE standards when developing the state standards. The commissioner must periodically review and update the standards. If a health carrier makes any material modification in any of the terms of the plan that is not reflected in the most recent SBCE, it must provide notice of the modification no less than 60 days prior to the date the modification becomes effective.

A health carrier that fails to provide the required information is subject to a fine of no more than $1,000 for each failure. A failure for each enrollee constitutes a separate offense.

The commissioner must develop standards for definitions of terms to be used on health insurance coverage, including insurance-related terms and medical terms.

Waiting Periods for Group Coverage. A group health plan and a health carrier offering group coverage may not apply any waiting period that exceeds 90 days.

Non-Discrimination. A health carrier may not make coverage decisions, determine reimbursement amounts, establish incentive programs, or design benefits in a way that discriminates against individuals because of their age, disability, or life expectancy. Health carriers must ensure that essential health benefits are not subject to denial based on age, life expectancy, disability, degree of medical dependency, or quality of life. Qualified health plans may not employ marketing practices or benefit designs that have the effect of discouraging enrollment in the plan by individuals with significant health needs.

Rulemaking. Unless preempted by federal law, the commissioner must adopt any rules necessary to implement the provisions relating to guaranteed issue and eligibility, open enrollment periods, limitations on rescissions, essential health benefits, out-of-pocket maximums, prohibiting annual or lifetime limits, uniform explanation of coverage requirements, maximum waiting periods for group coverage, and discrimination prohibitions. The rules must be consistent with federal rules and guidance in effect on January 1, 2017, implementing the ACA.

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: PRO: When the ACA past in 2010, it took away fear that people would be denied health care coverage, or dropped from coverage. This bill seeks to ensure people of Washington will be protected, regardless of what happens at the federal level. This bill protects denials of coverage for people with preexisting conditions and codifies the essential health benefits. These provisions directly impact patients. Lifetime caps significantly affect families with chronic diseases. People with preexisting conditions need insurance that covers them, to ensure they can stay employed. Every time the federal government threatens to remove these protections, it terrifies families and patients. Without these protections prohibiting coverage discrimination, people with preexisting conditions might get coverage, but might not have coverage that pays for their conditions.

Persons Testifying: PRO: Representative Lauren Davis, Prime Sponsor; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Alexa Silver, Northwest Health Law Advocates.

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