**Washington State**
**House of Representatives**
**Office of Program Research**

# BILL ANALYSIS

# Health Care & Wellness Committee

# HB 1870

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

**Sponsors**: 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 Summary of Bill**

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

**Hearing Date**: 2/12/19

**Staff**: Jim Morishima (786-7191).

**Background**:

Passed in 2010, the federal Patient Protection and Affordable Care Act (ACA) enacted a variety of provisions related to private health insurance coverage, including community rating, guaranteed issue and eligibility, open enrollment periods, limitations on rescissions, essential health benefits, out-of-pocket maximums, prohibiting annual or lifetime limits, minimum medical loss ratios, uniform explanation of coverage requirements, and maximum waiting periods for group coverage.

The ACA preempts state laws that prevent its application. Washington law includes some provisions that conflict with the ACA and are therefore not enforced. Additionally, state law includes provisions implementing the ACA, although some of the provisions of the ACA are not addressed in state law.

I. Modified Community Rating.

A. Federal Law.

---

*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.*

The ACA limits the circumstances under which most individual and small group market health plans may vary a person's premium rates. Non-grandfathered individual and small group market health plans may only vary a person's premium based on:

- whether the plan covers an individual or a family;
- geographic rating area (established by the states based on federal guidance);
- age, except that the rate may not vary by more than three to one for adults; or
- tobacco use, except that the rate may not vary by more than one and one-half to one.

B. State Law.

State law also limits the circumstances under which individual and small group market health plans may vary a person's premium rates. Individual and small group market health plans may only vary a person's premium based on:

- geographic area;
- family size;
- age;
- tenure discounts; and
- wellness activities.

II. Guaranteed Issue and Eligibility.

A. Federal Law.

The ACA requires most health insurers to accept every employer or individual who applies for coverage. Health carriers are prohibited from imposing pre-existing condition exclusions or waiting periods. Health carriers are also prohibited from establishing 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 Secretary of Health and Human Services (Secretary).

B. State Law.

State law includes provisions relating to guaranteed issue and pre-existing conditions that are not enforced because of the ACA. For example, state law requires an individual to complete the standard health questionnaire prior to purchasing an individual market health insurance plan. Based on the results of the questionnaire, the person may be denied individual market coverage, in which case he or she is eligible to purchase coverage from the Washington State Health Insurance Pool. State law also includes provisions allowing for pre-existing condition waiting periods, except for persons under the age of 19. Because of the rating rules under federal law, the state rating rules only apply to health plans that are grandfathered under the ACA.

III. Open Enrollment Periods.

A. Federal Law.

The ACA allows health carriers to restrict enrollment in health plans to open or special enrollment periods. Open enrollment periods occur once per year. A person who misses open enrollment may enroll in a health plan during a special enrollment period upon the occurrence of a life event such as losing health coverage or the birth of a child.

B. State Law.

The Insurance Commissioner (Commissioner) is required to establish open enrollment periods for person under the age of nineteen. The Commissioner may levy fines against a carrier that refuses to sell guaranteed issue policies to persons under the age of nineteen.

IV. Rescissions.

A. Federal Law.

The ACA prohibits health carriers from retroactively rescinding coverage except in cases involving fraud or material misrepresentation.

B. State Law.

State law does not prohibit rescissions. However, the reasons for which a carrier may cancel coverage are limited to non-payment of premium, violations of the published policies of the carrier, Medicare eligibility, failure to pay cost-sharing, fraud, material breach of contract, or changes in state or federal law.

V. Essential Health Benefits.

A. Federal Law.

The ACA requires most individual and small group market health plans to cover 10 categories of essential health benefits:

- 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;
- laboratory services;
- preventive and wellness services and chronic disease management;
- pediatric services, including oral and vision care.

To determine the specific services covered within each category, federal rules allow states to choose a benchmark plan and to supplement that plan to ensure it covers all 10 categories.

B. State Law.

State law designates the largest small group plan in the state as the benchmark plan. Consistent with federal law, the Commissioner must supplement the benchmark plan to ensure that all 10 categories of essential health benefits are included.

VI. Out-of-Pocket Maximums.

A. Federal Law.

The ACA imposes a maximum for the out-of-pocket costs associated with the essential health benefits an enrollee must pay per plan year. The Secretary sets the maximum for individual and family coverage. The Secretary may adjust the amounts based on increases in premiums for the previous calendar year. Federal rules prohibit a person's out-of-pocket maximum from exceeding the limit for self-only coverage, regardless of whether he or she is enrolled in self-only or family coverage.

B. State Law.

State law does not address the federal out-of-pocket maximums.

VII. Lifetime Limits.

A. Federal Law.

The ACA prohibits health plans from imposing annual or lifetime limits on an essential health benefit for a particular beneficiary.

B. State Law.

Rules adopted by the Commissioner prohibit a health carrier from imposing annual or lifetime limits on an essential health benefit, other than those permitted as reference-based limitations.

VIII. Medical Loss Ratios.

A medical loss ratio is the amount that a health insurer must spend on health care as opposed to overhead and other expenses.

A. Federal Law.

The ACA requires health carriers in the large group market to maintain a minimum medical loss ratio of 85 percent and health carriers in the individual and small group markets to maintain a minimum medical loss ratio of 80 percent. The Secretary may, by rule, increase the medical loss ratios.

A health carrier that does not meet the minimum medical loss ratios must provide an annual, pro-rata rebate to each enrollee. The amount of the rebate must equal the product of the amount by which the carrier's medical loss ratio exceeds the required ratio and the total amount of premium revenue, excluding taxes, fees, and payments or receipts received under the federal risk adjustment program.

All health carriers subject to the medical loss ratio requirements must submit to the federal government a report regarding the ratio of the incurred loss or incurred claims plus the loss adjustment expense or change in contract reserve to earned premiums. The report must include the percentage of premium revenue, after accounting for adjustments under the federal risk adjustment program, that the coverage expends on reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claim costs, excluding taxes and regulatory fees.

B. State Law.

As part of the rate filing process, state law requires health carriers to submit supporting documents, including an actuarial certification that a plan's expected medical loss ratio will be at least 74 percent.

IX. Explanation of Coverage.

A. Federal Law.

Under the ACA, 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 policyholder certificate holder at the time of issuance.

The ACA requires the Secretary to develop standards for health carriers to use when providing a SBCE to applicants, enrollees, and policyholders. The standards must require that the SBCE is 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, limitations, 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 that 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 that 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 web site where a copy of the actual individual coverage policy or group certificate of coverage may be reviewed and obtained.

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

B. State Law.

There are no state requirements regarding the SBCE.

X. Waiting Periods for Group Coverage.

A. Federal Law.

A health carrier may not apply a waiting period for group coverage that exceeds 90 days.

B. State Law.

State law does not address waiting periods for group coverage.

**Summary of Bill**:

I. Modified Community Rating.

A non-grandfathered individual and small group market health plan may only vary a person's premium based on:

- whether the plan covers and individual or a family;
- geographic rating area;
- age, except that the rate may not vary by more than three to one for adults; or
- tobacco use, except that the rate may not vary by more than one and one-half to one.

The Insurance Commissioner (Commissioner) must adopt rules establishing geographic rating areas and permissible age bands. The rating variations permitting for tobacco use must be applied based on the portion of the premium attributable to each family member covered by the plan.

Provisions relating to premium rating factors that conflict with federal law are made applicable only to grandfathered health plans.

II. 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 Commissioner.

III. 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.

IV. Rescissions.

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

V. Essential Health Benefits.

The 10 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;
- laboratory services;
- preventive and wellness services and chronic disease management;
- 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.

VI. 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 is 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.

VII. 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.

VIII. Medical Loss Ratios.

A health carrier in the large group market must maintain a minimum medical loss ratio of 85 percent. A health carrier in the individual or small group market must maintain a minimum medical loss ratio of 80 percent. The Commissioner may, by rule, increase the medical loss ratios.

A health carrier that does not meet the minimum medical loss ratios must provide an annual, pro-rata rebate to each enrollee. The amount of the rebate must equal the product of the amount by which the carrier's medical loss ratio exceeds the required ratio and the total amount of premium revenue, excluding taxes, fees, and payments or receipts received under the federal risk adjustment program.

A health carriers subject to the medical loss ratio requirements must submit to the Commissioner a report regarding the ratio of the incurred loss or incurred claims plus the loss adjustment expense or change in contract reserve to earned premiums. The report must include the percentage of premium revenue, after accounting for adjustments under the federal risk adjustment program, that the coverage expends on reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claim costs, excluding taxes and regulatory fees.

Provisions relating to supporting documents, including an actuarial certification that a plan's expected medical loss ratio will be at least 74 percent, are repealed.

IX. 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 policyholder 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 must require that the SBCE is 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 that 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 that 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 web site 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.

X. 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.

XI. Rulemaking.

Unless preempted by federal law, the Commissioner must adopt any rules necessary to implement the provisions relating to community rating, guaranteed issue and eligibility, open enrollment periods, limitations on rescissions, essential health benefits, out-of-pocket maximums, prohibiting annual or lifetime limits, minimum medical loss ratios, uniform explanation of coverage requirements, and maximum waiting periods for group coverage. The rules must be consistent with federal rules and guidance in effect on January 1, 2017, implementing the Patient Protection and Affordable Care Act.

**Appropriation**: None.

**Fiscal Note**: Requested on February 6, 2019.

**Effective Date**: The bill takes effect 90 days after adjournment of the session in which the bill is passed.