Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2554

Brief Description: Mitigating inequity in the health insurance market caused by health plans that exclude certain mandated benefits.

Sponsors: Representatives Stonier, Cody, Macri, Riccelli, Robinson, Tharinger, Senn, Peterson, Valdez, Davis, Doglio, Dolan, Fitzgibbon, Walen, Frame, Ramel, Pollet, Ryu, Goodman, Lekanoff, Ormsby and Chapman.

Brief Summary of Bill

- Requires health carriers and the Health Benefit Exchange to provide certain notices to consumers when mandatory benefits are excluded from health plans.
- Allows the Insurance Commissioner to assess a fee on a health carrier that excludes certain mandatory benefits.

Hearing Date: 1/29/20

Staff: Jim Morishima (786-7191).

Background:

Health carriers are required to offer health plans that include certain benefits mandated by state and federal law. For example, 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 also includes mandated health benefits not required under the ACA. For example, state law requires health plans that include maternity care coverage to 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.

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.

A health carrier that does not participate 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:

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 all of its marketing materials for the plan. The information must also be listed in the benefit booklet and posted on the carrier's health plan or student health plan web site.

Beginning July 1, 2021, the Health Benefit Exchange (Exchange) must provide individuals seeking to purchase coverage on its web site with access to the information that carriers must provide when they exclude mandated benefits. The Exchange must provide this access directly on its web site, 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 may assess a fee on any health carrier offering a health plan or student health plan if the health plan or student health plan excludes, under state or federal law, any essential health benefit or benefit that is required under state law or rule. The fee must be the actuarial equivalent of costs attributed to the provision and administration of the excluded benefit. The fee must be deposited into the General Fund.

Appropriation: None.

Fiscal Note: Available.

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