FINAL BILL REPORT
ESHB 1957

C 314 L 24
Synopsis as Enacted

Brief Description: Preserving coverage of preventive services without cost sharing.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Riccelli, Macri, Ryu, Leavitt, Senn, Reed, Ormsby, Callan, Doglio, Fosse, Goodman, Lekanoff, Wylie, Pollet and Davis).

House Committee on Health Care & Wellness
Senate Committee on Health & Long Term Care

Background:

The federal Patient Protection and Affordable Care Act (ACA) requires health plans to cover the following preventive services with no cost sharing:

- evidence-based items or services with an A or B rating from the United States Preventive Services Task Force (USPSTF);
- immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
- preventive care and screenings for infants, children, and adolescents provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA); and
- additional preventive care and screenings for women are provided for in comprehensive guidelines supported by the HRSA.

Preventive services covered by this requirement include:

- immunizations for certain diseases, including diphtheria, hepatitis, influenza, and measles;
- certain screenings for children, including for lead exposure, oral health, vision, and autism;
- blood pressure and cholesterol screenings;
- screenings for certain diseases, including diabetes and HIV;

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- certain screenings for pregnant women, including for gestational diabetes, maternal depression, and preeclampsia;
- pre-exposure prophylaxis HIV medication;
- certain cancer screenings, including breast, lung, and colorectal cancer screening; and
- contraception for women.

State law requires health plans issued or renewed on or after June 7, 2018, to provide coverage without cost sharing for the same preventive services required to be covered under the provision of the ACA summarized above and any federal rules or guidance in effect on December 31, 2016, implementing the law. The Insurance Commissioner (Commissioner) must enforce this requirement consistent with federal rules, guidance, and case law in effect on December 31, 2016.

Summary:

A nongrandfathered health plan issued or renewed on or after June 6, 2024, must provide coverage without cost sharing, except as provided below, for the following preventive services as the recommendations or guidelines existed on January 8, 2024:

- evidence-based items or services that have a rating of A or B in the current recommendations of the USPSTF;
- immunizations for routine use in children, adolescents, and adults recommended by the ACIP of the CDC;
- preventive care and screenings for infants, children, and adolescents provided for in comprehensive guidelines supported by the HRSA; and
- preventive care and screenings for women provided for in comprehensive guidelines supported by the HRSA.

For purposes of recommended immunizations, a recommendation from the ACIP is considered in effect after the recommendation has been adopted by the Director of the CDC, and a recommendation is considered to be for routine use if the recommendation is listed on the immunization schedules of the CDC. The reference to the federal law citation is removed.

A nongrandfathered health plan must provide coverage for the required preventive services consistent with federal rules and guidance related to coverage of preventive services in effect on January 8, 2024. A nongrandfathered health plan is not required to provide coverage for any items or services specified in any recommendation or guideline, if the recommendation or guideline is revised by the federal recommending entities to no longer include the preventive item or service. A nongrandfathered health plan must provide coverage for the required preventive services for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued. Annually, a health carrier must determine whether any additional items or services must be covered without cost sharing or whether any items or services are no longer required to be covered, which must be included in the health plan filings submitted to the Commissioner.

The prohibition on imposing cost sharing for preventive services is limited to when the services are provided by an in-network provider. If a plan does not have an in-network provider who can provide a preventive item or service, the plan must cover the item or service when performed by an out-of-network provider and not impose cost sharing for the item or service. If any portion of the federal law is found invalid for high deductible health plans with a health savings account, the health carrier may apply cost sharing to the services that have been invalidated at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account.

A health carrier may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the relevant recommendation or guideline, federal rules and guidance related to the coverage of preventive care in effect on January 8, 2024, and Commissioner rules. The Commissioner must enforce these requirements consistent with federal rules and guidance in effect on January 8, 2024.

The Commissioner is authorized to adopt rules necessary to implement these requirements consistent with federal statutes, rules, and guidance in effect on January 8, 2024. The Commissioner may also adopt rules related to any future preventive services recommendations or guidelines from the USPSTF, the ACIP, and the HRSA as described above or related rules or guidance.

Votes on Final Passage:

House	97	0	
Senate	49	0	(Senate amended)
House	97	0	(House concurred)

Effective: June 6, 2024