SENATE BILL REPORT
ESHB 1957

As Reported by Senate Committee On:
Health & Long Term Care, February 20, 2024

Title: An act relating to preserving coverage of preventive services without cost sharing.

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).

Brief History: Passed House: 2/8/24, 97-0.
Committee Activity: Health & Long Term Care: 2/16/24, 2/20/24 [DPA].

Brief Summary of Amended Bill

- Modifies the requirement for health carriers to cover the same preventive services without cost sharing as required by federal law.
- Authorizes the Insurance Commissioner to adopt rules related to any future preventive services recommendations or guidelines from the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the United States Health Resources and Services Administration or related rules or guidance.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass as amended.
Signed by Senators Cleveland, Chair; Robinson, Vice Chair; Muzzall, Assistant Ranking Member; Conway, Dhingra, Holy, Padden, Randall and Van De Wege.

Staff: Greg Attanasio (786-7410)

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Background: The Affordable Care Act 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 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;
- 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 summarized above, and any federal rules or guidance in effect on December 31, 2016, implementing those statutory requirements. The Office of the Insurance Commissioner (OIC) must enforce this requirement consistent with federal rules, guidance, and case law in effect on December 31, 2016.

Summary of Amended Bill: A nongrandfathered health plan issued or renewed on or after the effect date of this act 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
- additional 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 no longer 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 OIC.

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 in its network a 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 OIC rules. OIC must enforce these requirements consistent with federal rules and guidance in effect on January 8, 2024.

OIC is authorized to adopt rules necessary to implement these requirements consistent with federal statutes, rules, and guidance in effect on January 8, 2024. OIC 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.

EFFECT OF HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Makes technical corrections to the names of federal organizations listed in the bill.

Appropriation: None.

Fiscal Note: Requested on February 13, 2024.

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 Engrossed Substitute House Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This bill updates the state law with new recommendations for preventative services. This bill provides certainty for carriers and consumers.

Persons Testifying: PRO: Stephanie Simpson, Bleeding Disorder Foundation of Washington; Jane Beyer, Office of the Insurance Commissioner; Jennifer Ziegler, Association of Washington Health Care Plans.

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