ANALYSIS OF HOUSE BILL HB 2360

Modifying access to individual health insurance coverage.

SPONSORS: Representatives Parlette and Buck.

BACKGROUND: Most people in Washington who receive their health insurance through the private market do so through their employer in what is referred to as the group market. However, individuals who are self-employed, or who are not provided coverage by their employers, must get insurance in the individual market. Approximately 200,000 - 250,000 state residents are currently insured through the individual market. There are also approximately 600,000 people without health insurance in the state for whom the individual market could potentially be a source of insurance.

Health plans in the individual market are governed by a set of state standards, many of which have been placed in statute or adopted in administrative rule since 1992. Among these are laws which: (1) prohibit a person from being denied enrollment in any individual health plan, regardless of his or her health status; (2) allow carriers to impose no more than a three-month waiting period for the coverage of any preexisting condition; (3) require that, under certain conditions, these waiting periods be waived for persons moving between plans; and (4) guarantee that once a person enrolls in a plan, that plan, or one with similar benefits, will be available to them on an on-going basis.

Health carriers are also required by law to include certain benefits in any health plan that is sold. In general, maternity services and prescription drug benefits are not among those items which state law mandates be covered. However, any carrier which offers coverage in the individual market must offer at least one plan modeled after the state's basic health plan. This plan does include maternity services and prescription drug benefits.

The premiums charged for individual health plans are also governed by state law. In general, it provides that the benefits be reasonable in relation to the amount charged.– In applying this standard to health maintenance organizations and health care service contractors, the Insurance Commissioner reviews requests for rate increases and disapproves those where the rate is based on a loss ratio– (the percentage of premiums paid out in medical claims) of less than 80 percent. For disability insurers, the loss ratio standard is 60 percent. Rate denials may be appealed, but such appeals are handled through an internal appeals process, not by the Office of Administrative Hearings.

Between 1993 and 1995, enrollment in the individual market expanded by 40 percent. At the end of this period, however, carriers began reporting significant losses in the individual market, and individual market rates, which were relatively flat initially, began increasing. In September, 1999 the three major carriers that remained in the market announced they would no longer offer individual health insurance in thirty-one of Washington's thirty-nine counties.

The Washington State Health Insurance Pool (WSHIP) was created in 1988 to provide a fee-for-service health

PREPARED BY: *Dave Knutson, Senior Research Analyst*
House Health Care Committee, P.O. Box ***40600***
Olympia, WA. 98504-0600, (360) 786-7146

insurance product at 150 percent of average rates for individuals who had been denied substantially equivalent– coverage by a carrier, usually because of serious medical conditions. In 1997, WSHIP was directed to develop a managed care product to be available at 125 percent of average. However, because coverage can no longer be denied by carriers, WSHIP has been essentially dormant since 1993. It now provides coverage to approximately 800 people, most of whom receive a Medicare supplement policy. Any new entrants into the pool are subject to a three-month preexisting condition waiting period.

WSHIP is administered by a private insurer according to state specifications and is partially subsidized through an assessment on insurers. A board of directors, comprised mainly of insurance carriers, oversees its operation.

The Washington Basic Health Plan (BHP) is a state-sponsored health insurance program for any Washington resident who is not eligible for Medicare and not institutionalized at the time of enrollment. Every enrollee pays a monthly premium based on income, age, family size, and the health plan they choose. The state helps pay part of the premium for members who meet income guidelines.

The BHP is administered by the state Health Care Authority (HCA). It solicits bids from private health carriers to cover both subsidized and non-subsidized enrollees. Currently, there are about 127,500 persons whose enrollment in the BHP is subsidized, and 8,400 persons whose enrollment is not.

The enabling statute directs the BHP to provide coverage though contracts with managed care health systems,– defined to include organizations that provide health care services on a prepaid capitated basis. The HCA is not authorized to self-insure the BHP.

SUMMARY: The standards governing health benefit plans in the individual market are changed as follows:

The Washington State Health Insurance Pool is changed as follows: A person may receive coverage through the pool if: (1) he or she applied for individual coverage from a carrier, but did not get coverage as a result of the health questionnaire. A carrier may refer no more than 8 percent of its applicants per year to WSHIP.

Premiums for pool coverage are set at 150 percent of the average market rate of comparable individual insurance for the fee-for-service plan, and 125 percent of that rate for a care management plan.

Each year, carriers may deny enrollment to up to eight percent of those who apply for individual health plan coverage. The denial must be based on the results of a standard health questionnaire developed by the board of the WSHIP. Anyone denied coverage by a carrier may enroll in the WSHIP.

New individual enrollees will be subject to a twelve-month preexisting condition waiting period.

Except for those moving from a catastrophic to a comprehensive plan, a person moving between plans continues to receive credit for any time served– against any preexisting condition waiting period. However, in most cases, the person can be required to take the health questionnaire and possibly be referred to WSHIP. Exceptions to this are provided for a person who moves, or who switches plans to follow his or her doctor.

Once enrolled in a health plan, a person must be allowed to renew coverage in that plan, or, if that plan is discontinued, in any other plan offered to individuals by his or her health carrier.

The requirement that health carriers in the individual market offer the BHP model plan is removed.

For purposes of establishing rates, a loss ratio standard of 72 percent minus the premium tax percentage rate (currently two percent) is set in statute. Carriers are allowed to charge rates in the individual market as long

as they are targeted to this loss ratio. If, in the following year, it is determined that the carrier's actual loss ratio was lower than the loss ratio standard, the carrier must refund the difference to the WSHIP. Any appeals of rate review issues is presided over by an administrative law judge from the Office of Administrative Hearings. Licensees under Title 48 RCW are also authorized to request an administrative law judge to preside over other dispute hearings.

The requirement that the BHP be delivered on a prepaid capitated basis is removed.

The BHP will continue to give priority to prepaid managed care as the preferred method of assuring access. The Health Care Authority is authorized to self-insure the Basic Health Plan.