SENATE BILL REPORT

E2SSB 6067

As Passed Senate, February 29, 2000

Title: An act relating to access to individual health insurance coverage.

Brief Description: Modifying provisions concerning access to individual health insurance coverage.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senator Thibaudeau).

Brief History:
Committee Activity: Health & Long-Term Care: 4/20/99, 4/21/99 [DPS, DNP]; 1/20/00, 2/3/00 [DP2S].
Passed Senate, 4/24/99, 26-23; 2/29/00, 43-5.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Second Substitute Senate Bill No. 6067 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Thibaudeau, Chair; Wojahn, Vice Chair; Costa, Deccio, Franklin, Johnson and Winsley.

Staff: Jonathan Seib (786-7427)

Background: As in other states, 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, those who are not provided coverage by their employer must get insurance in the individual market. Approximately 200,000 to 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 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. However, at the end of this period, carriers began reporting significant individual market losses, and rates began to increase. Within the past year, the three major carriers in the individual market, cited such losses, decided to no longer sell individual plans. Currently, commercial individual coverage is not available to new enrollees in 30 of the state's 39 counties.

The explanation for the market's behavior includes many complex factors. Some suggest that new enrollees entering the market under the existing standards tend to use more health care services, and claims submitted to carriers have increased. Generally, as rates increase without incentives for healthy people to maintain continuous coverage, the possibility exists that adverse selection will occur, where healthy people who least expect to need expensive care choose not to have health coverage, or choose to enter the market only when needing major medical care and dropping coverage after receiving medical treatment.

The Washington State Health Insurance Pool (WSHIP) was created in 1988 to provide a fee-for-service 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 the average. But because coverage could no longer be denied by carriers, WSHIP had been essentially dormant since 1993. In the summer of 1999, however, WSHIP eligibility was expanded to allow anyone residing in an area of the state without commercial individual coverage to enroll. It now provides coverage to approximately 1400 people. 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 128,500 persons whose enrollment in the BHP is subsidized, and 3,000 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 pre-paid capitated basis. The HCA is not authorized to self-insure the BHP.

It is becoming increasingly difficult for the HCA to provide BHP coverage in some areas of the state, particularly rural counties, and is suggested that giving the HCA more flexibility in BHP program design may help alleviate this problem. In addition, there is concern that the problems in the state's individual market, which have dramatically affected the unsubsidized program, could also threaten the subsidized program since the two programs are bid together.

Summary of Bill: The standards governing health benefit plans, primarily in the individual market, are changed as follows:

Each year, carriers as a whole may deny enrollment to up to 8 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 enrollees in individual health benefit plans, or group plans for 50 persons or less, may be subject to a preexisting condition waiting period of no more than nine months. Prenatal care may not be subject to any waiting period in the individual market. The pre-existing condition waiting period for pregnancy in group plans must comply with the federal Health Insurance Portability and Accountability Act.

A person moving between individual plans will receive credit for any time served– against any preexisting condition waiting period if the plan to which he or she is moving includes benefits which are equal to or greater than the plan from which he or she is moving. 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. In such cases, they may not be required to take the health questionnaire. Carriers must give 90 days notice of the discontinuation of any plan.

The requirement that health carriers in the individual market offer the BHP model plan is removed. However, carriers are required to provide coverage of maternity services and at least a $2000 prescription drug benefit in any comprehensive individual policy.

For purposes of establishing rates, a loss ratio standard of 74 percent minus the premium tax percentage rate (currently 2 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 remit the difference to WSHIP. Any appeals of rate review issues is presided over by an administrative law judge from the Office of Administrative Hearings.

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; or (2) no private individual comprehensive plan is being marketed in his or her county, and he or she applies directly to the pool.

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. Reduced premiums are provided for those who have been in a comprehensive plan for 18 months or more prior to their being screened into WSHIP. A tenure discount, and discounts for those aged 50-64 whose family income is below 301 percent of the federal poverty level, are provided. The latter discounts are dependent on state funding.

In addition to health carriers, stop loss insurers and the state Health Care Authority (only for purposes of the Uniform Medical Plan) are added as members of the pool against whom assessments are made to cover the pool's losses. Both, however, are assessed at a lower rate than other carriers. A fund is also established into which state dollars may be appropriated. The fund is drawn upon to cover pool losses only if the assessments required of pool members reach 70 percent per insured person per month.

The pool board of directors is reconfigured to include a total of 10 members, six of whom are appointed by the Governor and four of whom are appointed by the carriers. The Insurance Commissioner is a nonvoting member.

The preexisting condition waiting period in WSHIP is changed from three to six months.

To the extent state funds are specifically provided for this purpose, the Health Care Authority is directed to offer a catastrophic-type health plan. The plan is available to any person who resides in a county where no comprehensive private individual coverage is offered, until such coverage is offered.

The subsidized and the unsubsidized Basic Health Plan are de-linked– through language which explicitly allows them to be bid separately by the health carriers.

In addition, the requirement that the BHP be delivered on a prepaid capitated basis is removed.

BHP benefits need not be the same, but must be actuarially equivalent, for similar enrollees.

The BHP administrator is authorized to negotiate additional contracts after the request for proposal process is completed if doing so is necessary to meet the access needs of BHP enrollees.

The Health Care Authority is explicitly authorized to self-insure the Basic Health Plan. A Basic Health Plan self-insurance reserve account is created and rules governing its operation are established.

The BHP is to continue to give priority to prepaid managed care as the preferred method of assuring access. The use of a self-insured, self-funded option is limited to the subsidized BHP enrollees and only if funding is available in the BHP self-insurance reserve account and specified conditions are met regarding price.

An executive/legislative task force is created to monitor the provisions of the act and its effect on carriers and consumers in the individual and small group markets, and on WSHIP and the BHP. The task force is also to study the feasibility of reinsurance as a method of health insurance market stability and, if appropriate, develop a reinsurance system implementation plan. It is to submit preliminary reports to the Governor and the Legislature each year, and a final report by December 2002.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill contains an emergency clause and takes effect immediately.

Testimony: It is crucial that the Legislature act to revitalize the individual insurance market. Consumers and business should not be adversely impacted by any changes adopted. The parties are committed to working on a solution that will pass this session.

Testified: Deborah Senn, Insurance Commissioner; Barb Flye, Washington Citizen Action and Northwest Health Law Advocates; Andrea Stepherson, The Empower Alliance; Trent House, Pam MacEwan, Callie Denton, Jack McRae, Association of Washington Health Care Plans; Lonnie Johns-Brown, National Organization for Women, National Association of Social Workers; John Vipowd, Association of Washington Business; Tanis Marsh, League of Women Voters; Joel Hasting, NW Aids Foundation; Nick Federici, Lung Association; Jim Halstrom, Health Care Purchasers Association, Master Builders of King County.