SENATE BILL REPORT

SB 6067

As Reported By Senate Committee On:
Health & Long-Term Care, April 21, 1999

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

Brief Description: Establishing principles for affordable health insurance coverage.

Sponsors: Senator Thibaudeau.

Brief History:
Committee Activity: Health & Long-Term Care: 4/20/99, 4/21/99 [DPS, DNP].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: That Substitute Senate Bill No. 6067 be substituted therefor, and the substitute bill do pass.
Signed by Senators Thibaudeau, Chair; Wojahn, Vice Chair; Deccio and Winsley.

Minority Report: Do not pass.
Signed by Senators Costa and Franklin.

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 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 ration 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. More recently, the three major carriers that remained in the market have reported significant losses on individual plans. Currently, individual plans are not available to new enrollees in 17 counties in the state.

The explanation for the market's behavior could include 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 health 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 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 Substitute Bill: The standards governing health benefit plans in the individual market are changed as follows:

Each year, carriers 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 individual enrollees must be given a choice between the following: (1) a six-month preexisting condition waiting period, with additional out-of-pocket expenses for the next six months on that preexisting condition of up to $4500 (indexed to inflation); or (2) a ninth month preexisting condition waiting period. In either case, prenatal care is not subject to any 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. 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 (indexed to inflation) 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 refund the difference, plus interest, to policy holders. Any appeals of rate review issues is presided over by an administrative law judge from the Office 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) he or she applies directly to the pool and the health questionnaire shows them to have a serious health problem. 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. A tenure discount and discounts for those whose family income is below 300 percent of the federal poverty level, are provided.

In addition to health carriers, stop loss insurers are added as members of the pool against whom assessments are made to cover the pool's losses. 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 11 members, six of whom are appointed by the Governor and five of whom are appointed by the carriers. The insurance commissioner is a nonvoting member.

The three month preexisting condition waiting period in the pool may be waived upon certification by a physician that a person has a life-threatening condition that will deteriorate if not treated within the three month period.

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 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: (1) it is necessary to meet access needs; (2) funding is available in the BHP self insurance reserve account; and (3) other options to address access needs of subsidized enrollees are not feasible.

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.

An executive/legislative task force on health care reinsurance is created to monitor the provisions of the act and its effect on carriers and consumers in the individual market, 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 develop a reinsurance system implementation plan. It is to report to the Governor and the Legislature by December, 2000.

The act expires January 1, 2004.

Substitute Bill Compared to Original Bill: The original bill was not considered.

Appropriation: $125,000.

Fiscal Note: Requested on April 19, 1999.

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

Testimony For: It does not do the state any good to let the individual health insurance market continue to deteriorate. This bill is a reasonable compromise that will stabilize the market and make coverage available in counties where it cannot now be purchased. It is an immediate answer to an immediate problem. The health carriers cannot continue to sustain tremendous losses in the individual market. Absent this legislation, the market will continue to collapse.

Testimony Against: This legislation reduces access and does not sufficiently spread risk. It provides no guarantees that insurance will be more available, and does not adequately address affordability. The public will be shocked by the introduction of health screening, which is discriminatory. Reducing the authority of the Insurance Commissioner will be detrimental to consumers. The bill provides insurance companies with guaranteed profits and reduces oversight. It will simply shift costs to the small-group market. Market stability cannot be achieved while increasing costs. A bill that brings only a few carriers back into the market will not provide the competition needed for a real solution. Different short-term reforms should be put in place while a longer term solution is developed.

Testified: PRO: Tom Curry, Washington State Medical Association; Andy Davidson, Washington State Hospital Association; Trae Anderson, Premera Blue Cross; Callie Denton, Regence; Pam Macewan, Group Health; Gary Christenson, Health Care Authority. CON: Margaret Hernandez, Victoria Doyle, Virginia Corhart, Deana Knutsen, Barb Flye, Washington Citizen Action; Basil Badley, HIAA; Nancee Wildermuth, PacificCare of Washington; Nick Federici, American Lung Association of Washington; Lonnie Johns-Brown, Washington State NOW; Gary Smith, Independent Business Association; Enid Layes, Washington State Horticulture Association; Carolyn Logue, National Federation of Independent Business, Julie Murray, Farm Bureau; Jim Halstrom, Health Care Purchasers Association, Association of Washington Business; David Allen, American Cancer Society; Deborah Senn, Insurance Commissioner.