Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2355

Brief Description: Addressing the establishment of an individual health insurance market claims-based reinsurance program.

Sponsors: Representative Cody; by request of Insurance Commissioner.

Brief Summary of Bill

- Establishes a claims-based reinsurance program for individual market health plans.

Hearing Date: 1/9/18

Staff: Jim Morishima (786-7191).

Background:

I. Individual Market Health Insurance.

Under the federal Patient Protection and Affordable Care Act (ACA), all United States citizens and legal residents must have health insurance coverage or pay a tax penalty (the tax penalty was recently set at zero by recently enacted federal legislation). People may comply with this requirement in a variety of ways, including through a state or federal program (e.g., Medicaid or Medicare), group coverage (e.g., employer sponsored insurance coverage or self-funded employer coverage), or the individual market.

People may purchase individual market insurance on the Health Benefit Exchange (Exchange), through which people may compare plans and access federal premium assistance. People may also purchase individual market coverage outside of the Exchange. State and federal law subject individual market health carriers to a variety of requirements and prohibitions, including guaranteed issue, coverage mandates, community rating, rate review, and minimum medical loss ratios.

II. Risk Levelling under the Patient Protection and Affordable Care Act.

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

The ACA created three risk levelling programs to address adverse selection inside and outside of the Exchange—risk adjustment, risk corridors, and reinsurance.

- Risk Adjustment: The risk adjustment program assesses plans with lower-risk enrollees and makes disbursements to plans with higher-risk enrollees. To operate the program, insurers are required to provide the federal government with de-identified data through a dedicated distributed data environment.
- Risk Corridors: The risk corridor program was designed to compensate for the difficulty of establishing initial premium rates in the individual market. Plans that had lower than expected costs made payments to the federal government, which then disbursed those funds to plans with higher than expected costs.
- Reinsurance: The reinsurance program required most health plans to contribute funds for disbursement to individual market plans with higher-cost enrollees.

Both the risk corridor and reinsurance programs expired in 2016.

IV. Section 1332 Waivers.

Section 1332 of the ACA authorizes states to apply to the Secretary of Health and Human Services and the Secretary of the Treasury for a waiver from certain provisions of the ACA for plan years beginning in 2017. A waiver may be granted if the state plan will provide coverage that is at least as comprehensive and affordable as coverage under the ACA to at least a comparable number of people, without increasing the federal deficit. The application must include a description of the state legislation, a program to implement a plan meeting the requirements for a waiver, and as a 10-year budget plan that is budget neutral for the federal government.

IV. The Washington State Health Insurance Pool.

The Washington State Health Insurance Pool (WSHIP) is Washington's high risk pool. The WSHIP provides coverage for:

- individuals ineligible for Medicare who were enrolled in WSHIP plans prior to January 1, 2014;
- individuals ineligible for Medicare who live in a county where individual health coverage is unavailable; and
- individuals eligible for Medicare who do not have access to a reasonable choice of Medicare Advantage plans and provide evidence of rejection for medical reasons, restrictive riders, an uprated premium, preexisting condition limitations, or lack of access to a comprehensive Medicare supplemental plan.

V. The Public Records Act.

The Public Records Act (PRA) requires state and local agencies to make all public records available for public inspection and copying, unless a record falls into one of the PRA's exemptions or another statute exempts or prohibits disclosure of specific information or records. For example, certain reports, data, documents, or other materials in the custody of the Insurance Commissioner for purposes of developing or implementing an individual health insurance market stability program are exempt from public inspection and copying. Likewise, certain data,

information, and documents relating to a report on school district health benefits are exempt from public inspection and copying (the report was eliminated in 2017).

The PRA is liberally construed in favor of disclosure and its exemptions narrowly construed. If the PRA conflicts with any other law, the provisions of the PRA govern.

Summary of Bill:

I. The Washington Reinsurance Program.

The Washington Reinsurance Program (WRP) is established for the stated purposes of stabilizing the rates and premiums for individual health plans and providing greater financial certainty to consumers. The WRP must reimburse health carriers for a percentage (the coinsurance rate) of individual market claims above a threshold (the attachment point) up to a cap (the reinsurance cap). The Insurance Commissioner (Commissioner) must annually set payment parameters for the program, which consist of the attachment point, coinsurance rate, and reinsurance cap, in order to:

- manage the program within available assessment resources and federal funding not to exceed the total program funding authorized by the Legislature;
- mitigate the impact of high-cost individuals on individual market premiums;
- stabilize or reduce individual market premiums; and
- increase participation in the individual market.

The Commissioner may request information from the WRP to determine adjustments to the payment parameters and may adjust the parameters by March 31 for the subsequent plan year. The attachment point for the program must be between $75,000 and the reinsurance cap. The coinsurance rate must be between 50 and 80 percent. The reinsurance cap must be between $500,000 and $1,000,000.

A health carrier is eligible for reinsurance payments once the claims cost for a reinsurance-eligible individual exceed the attachment point, but are below the reinsurance cap. The costs between the attachment point and the cap are then multiplied by the coinsurance rate to determine the payment. A health carrier receiving payments must implement care management practices for enrollees who are the subject of reinsurance claims. An eligible carrier must also calculate the premium amount it would have charged if the WRP had not been established and submit the information as part of its rate filing—the information must be considered as part of rate review.

To submit a claim for reinsurance, a health carrier must follow requirements established by the WSHIP's Board of Directors (Board). Claims data must be drawn from the federal dedicated distributed data environment used for the federal risk adjustment program.

On April 1 of the year following the applicable benefit year, the WRP must send an initial settlement report to each eligible health carrier in response to the carrier's final claims submission. By June 30, after resolution of any appeals, the WRP must disburse all applicable reinsurance payments to the carrier.

Reinsurance payments to eligible health carriers may not exceed $200,000,000 for any benefit year. If the payments are less than $200,000,000, the excess must be used to reduce health carrier assessments for the following year.

II. Program Administration.

The WRP is operated by the Board, which must:

- prepare and adopt amendments to the articles of organization and bylaws of the WSHIP to provide for the operation of the WRP;
- enter into contracts necessary to collect and disburse the assessment for reinsurance payments and to operate and administer the WRP;
- sue or be sued, including for the recovery for the assessment for reinsurance payments;
- appoint committees from Board members to provide technical assistance;
- hire independent consultants;
- conduct periodic audits;
- cause the WRP to be audited by an independent certified public accountant, who may be the same accountant as the WSHIP administrator;
- borrow and repay any working capital, reserve, or other funds necessary for the operation of the WRP;
- conduct all activities in accordance with an adopted reinsurance plan of operation; and
- perform any other functions to carry out the reinsurance plan of operation and to affect any or all of the purposes for which the WRP is organized.

On or before May 1, 2018, the Board must submit the reinsurance plan of operation to the Commissioner for review and approval. The plan must:

- provide for the operation of the WRP separate from the WSHIP;
- establish procedures for the handling and accounting of assets and moneys of the WRP;
- establish regular times and places for meetings of the Board in connection with the operation of the WRP;
- establish data and information requirements for submission of reinsurance payment requests, processes for the notification and issuance of reinsurance payments, and process to resolve reinsurance payment appeals;
- establish procedures for the collection of WRP assessments;
- establish procedures for recordkeeping procedures and annual reporting to the Commissioner;
- establish procedures for data submission by the WRP administrator to the Commissioner for preparation of quarterly and annual reports required under the terms of a Section 1332 waiver; and
- contain additional provisions necessary for the execution of the powers and duties of the WRP.

The Board must contract with entities under contract with the Board for WSHIP administration.

The WRP must submit an annual report to the Commissioner by November 1 or 60 calendar days after the final disbursement of reinsurance payments for the year, whichever is later. The report must include:

- funds received for reinsurance payments and WRP operations;

- requests for reinsurance payments received from eligible health carriers;
- reinsurance payments made to eligible health carriers; and
- administrative and operational expenses incurred for the program.

The WRP is subject to examination by the Commissioner.

III. Funding.

A. Health Carrier and Third-Party Administrator Assessments.

Health carriers and third-party administrators (TPAs) are subject to a "covered lives assessment" to fund reinsurance payments and WRP administrative expenses. A TPA is defined as any person or entity who, on behalf of a heath carrier or health care purchaser, receives or collects charges, contributions, or premiums for, or adjust or settles claims on or for, residents of Washington or Washington health care providers and facilities.

On or before September 1 of each year, the Board must determine the amount of the covered lives assessment to generate $200,000,000 per year in the upcoming benefit year for reinsurance claims plus program expenses of administration, including those incurred in connection with start-up of the program. The aggregate amount to be raised by the assessment in any year may be reduced by any surpluses in the account remaining from previous years.

A health carrier's or TPA's assessment is determined using a fraction. The numerator of the fraction is the health carrier's or TPA's total number of covered lives, including spouses and dependents, covered under all health plans by the health carrier or TPA during the preceding calendar year. The denominator of the fraction is the total number of covered lives, including spouses and dependents, covered under all health plans in the state by all health carriers and TPAs during the preceding calendar year.

By October 1 the Board must notify each health carrier and TPA of its estimated assessment and its payment obligation for the following year. The Board must determine a payment schedule for receipt of assessments. After notification, the health plan or TPA is allowed no more than 90 days to remit any amounts in arrears or submit a payment plan, subject to Board approval and submission of the first payment in the plan.

If the assessment against a health carrier or TPA is prohibited by court order, the assessment that would have been collected must be assessed against the other health carriers and TPAs.

The Board may abate or defer, in whole or in part, an assessment if, in the opinion of the Board, payment of the assessment would endanger the ability of the health carrier or TPA to fulfill its contractual obligations. The amount of any abatement or deferral may be assessed against other health carriers and TPAs, although the carrier or TPA receiving the abatement or deferral remains liable to the WRP for the deficiency. Upon receipt of payment of the abatement or deferral from the carrier or TPA, the future assessments on the other carriers and TPAs must be adjusted accordingly.

In developing assessment collection procedures, the Board must strongly consider the procedures used in the federal reinsurance program.

The Board must cause the program administrator to submit an annual report to the Commissioner listing health carriers and TPAs that failed to remit their assessments.

Beginning January 1, 2019, TPAs must register and renew annually with the Office of the Insurance Commissioner. Registrants must report a change of legal name, business name, business address, or business telephone number within 10 days. To the extent practicable, the Commissioner must adopt the data elements and procedures for registration and renewal adopted by the Washington Vaccine Association.

B. Section 1332 Waiver.

The Commissioner must apply to the federal government for a Section 1332 waiver to implement the WRP for benefit years beginning January 1, 2019, and future years to maximize federal funding. The operation of the WRP is contingent on receipt of the waiver and the application must clearly state so.

The Commissioner must make a draft application available for tribal consultation and public review and comment by March 1, 2018, and submit the waiver by April 1, 2018. The Commissioner must provide notification of any federal actions on the waiver request to the Board and the chairs and ranking members of the House Health Care and Wellness Committee, the House Appropriations Committee, the Senate Health Care Committee, and the Senate Ways and Means Committee.

C. Alternative Financing.

The Commissioner, in consultation with the Office of Financial Management, the Department of Revenue, the Health Care Authority, and the Exchange, must study alternative financing mechanisms for the WRP for calendar years 2021 through 2023. The Commissioner must evaluate the feasibility of a health care paid claims assessment and solicit input from interested parties. The Commissioner may contract with third parties for economic or actuarial analyses. The Commissioner must submit recommendations to the relevant committees of the Legislature on or before November 30, 2018. If the Legislature does not enact an alternative financing source on or before June 30, 2019, the Board will continue to collect assessments for calendar years 2021 through 2023 or until the Legislature has enacted an alternative financing source, whichever is earlier.

If additional federal funding opportunities for the WRP become available, the Commissioner must notify the relevant committees of the Legislature and pursue such funding.

D. The Washington Reinsurance Program Account.

The WRP Account (Account) is created as a non-appropriated account. All receipts from health carrier and TPA assessments, Section 1332 waiver funds, any alternative federal funds, and any additional appropriated funding must be deposited into the Account. Expenditures from the fund may only be used to operate the WRP and to make reinsurance payments to eligible health carriers. Only the Board may authorized expenditures from the Account. The Account is subject

to allotment procedures, but an appropriation is not required for expenditures. In making expenditures, federal funding must be expended first.

E. Appropriations.

The following appropriations are made:

- The sum of $450,000, or as much thereof as necessary, is appropriated from the General Fund to the Account for implementation and operation of the WRP until funds from the assessment are collected.
- The sum of $290,000, or as much thereof as necessary, is appropriated from the Commissioner's Regulatory Account for purposes of carrying out the Commissioner's duties relating to the WRP, including rule making, establishing payment parameters, program oversight, and implementation of a Section 1332 waiver.
- The sum of $100,000, or as much thereof as necessary, is appropriated from the General Fund-State to the Office of the Insurance Commissioner to pursue alternative financing for the WRP.

IV. Miscellaneous.

A. Public Records.

Data, information, and documents necessary to prepare the Section 1332 waiver, to determine reinsurance parameters, and to determine reinsurance claims payments are exempt from public inspection and copying. Reinsurance claims submitted to the WRP are also exempt from public inspection and copying.

The description of data, information, and documents relating to the report on school district health benefits is changed to reflect the fact that the requirement for the report was repealed.

B. Immunity.

The WRP, health carriers and TPAs assessed by the program, the Board, officers and employees of the WRP, the Commissioner and his or her representative and employees, are not civilly or criminally liable and may not have any penalty or cause of action of any nature arise against them for any action taken or not taken when the action or inaction is done in good faith and in the performance of statutory powers and duties. This does not prohibit legal actions against the WRP to enforce its statutory or contractual duties or obligations.

Appropriation: The sum of $450,000, or as much thereof as necessary, is appropriated from the General Fund to the Account for implementation and operation of the WRP until funds from the assessment are collected. The sum of $290,000, or as much thereof as necessary, is appropriated from the Commissioner's Regulatory Account for purposes of carrying out the Commissioner's duties relating to the WRP, including rule making, establishing payment parameters, program oversight, and implementation of a Section 1332 waiver. The sum of $100,000, or as much thereof as necessary, is appropriated from the General Fund-State to the Office of the Insurance Commissioner to pursue alternative financing for the WRP.

Fiscal Note: Requested on January 4, 2018.

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