SENATE BILL REPORT
SB 6062

As Reported by Senate Committee On:
Health & Long Term Care, January 23, 2018

Title: An act relating to establishment of an individual health insurance market claims-based reinsurance program.

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

Sponsors: Senators Cleveland, Frockt, Rolfes, Liias, Keiser, Saldaña and Kuderer; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long Term Care: 1/09/18, 1/23/18 [DPS-WM, DNP].

Brief Summary of First Substitute Bill

- Establishes a claims-based reinsurance program in Washington, including parameters for collecting assessments from health carriers and third party administrators, and for providing reinsurance payments to eligible health carriers and third party administrators.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6062 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Kuderer, Vice Chair; Conway, Keiser, Mullet and Van De Wege.

Minority Report: Do not pass.

Signed by Senators Rivers, Ranking Member; Bailey, Becker and Fain.

Staff: Evan Klein (786-7483)

Background: Washington State Health Insurance Pool. The Washington State Health Insurance Pool (WSHIP) is the high-risk pool for Washington. WSHIP is an independent, nonprofit entity created by legislation that provides coverage for individuals who are unable

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to obtain comprehensive health coverage or Medicare supplemental coverage. The program is funded through enrollee premiums and assessments placed on all regulated health plans, including Medicaid managed care plans and the state's self-insured Uniform Medical Plan.

Federal Reinsurance Program. The federal Affordable Care Act (ACA) created three premium stabilization programs to address adverse selection inside and outside of the Health Benefit Exchange (Exchange)—risk adjustment, reinsurance, and risk corridors. The Reinsurance Program, which expired in 2016, required most health plans, both inside and outside the Exchange, to contribute funds for disbursement to individual market plans with high-cost enrollees.

Reinsurance Waivers. Under section 1332 of the ACA, states may apply for innovation waivers to implement state-specific strategies that waive certain federal rules. Multiple states, including Alaska, Iowa, Minnesota, Oklahoma, and Oregon have submitted waivers to operate state-based reinsurance programs. Iowa and Oklahoma subsequently withdrew their waivers before final federal approval. Alaska, Minnesota, and Oregon have been approved by the Centers for Medicare and Medicaid (CMS) to begin operation of state reinsurance programs.

The two predominant types of reinsurance options are condition-based programs and claims-based programs. Conditions-based programs reimburse issuers for the claims of members who have certain conditions. Alaska adopted a condition-based reinsurance program in 2016, and it was approved by CMS in July 2017. Claims-based programs reimburse issuers for each member whose total claims hit a certain dollar amount. Minnesota and Oregon both adopted claims-based programs, and both received federal approval in 2017.

Market Stabilization Analysis. In 2017, the Insurance Commissioner (Commissioner) hired Wakely Consulting Group to undertake a market stabilization study to analyze policies to improve affordability and access to health care coverage. The Wakely report analyzed claims and condition based reinsurance programs, as well as several state-offered options. The report found that any of the reinsurance program options would reduce premiums and would be expected to reduce claims costs for issuers, but did not comment on the feasibility of funding mechanisms.

Summary of Bill (First Substitute): Program Creation. The Washington reinsurance program is established to stabilize the rates and premiums for individual health plans, and is to be operated by Washington Vaccine Association (WVA) through the Reinsurance Program Board (Board). The WVA must appoint the Board. The Board must prepare and adopt a reinsurance plan of operation and submit it to the Commissioner for approval. The Board is authorized to:

- enter into contracts as necessary;
- sue or be sued;
- appoint committees from among its members to provide technical assistance;
- hire consultants;
- cause the program to be audited;
- borrow and repay capital and reserves; and
- perform other functions as necessary to operate the program.

Reporting. The Board must submit financial reports to the Commissioner including:

- funds deposited in the reinsurance program account;
- requests for reinsurance payments from eligible health carriers; and
- administrative and operational expenses incurred.

The Commissioner must report on its website reports submitted to the federal government on the implementation of the waiver.

Plan of Operation. The Board must submit a reinsurance plan to the Commissioner by May 1, 2018, to include:

- procedures for accounting of assets;
- times and places for meetings;
- the amount of contingency funding necessary to ensure the continued operation of the program, not to exceed 10 percent.
- procedures to prevent the double counting of covered lives;
- a schedule and procedures for submission of information necessary to calculate the assessment;
- data and information requirements for submission of reinsurance payment requests;
- procedures for collection of assessments;
- procedures for keeping records; and
- procedures for submitting data to create quarterly reports.

Payments to Eligible Health Carriers. The Commissioner must annually determine the payment parameters for the program. The payment parameters for 2019 must be consistent with the parameters included in the state innovation waiver. For subsequent years, the parameters must be established by March 31.

The Commissioner must set the attachment point, the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits to become eligible for reinsurance payments, between $75,000 and the reinsurance cap. The Commissioner must set a coinsurance rate between 50 and 80 percent. The Commissioner must set a reinsurance cap, the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits over which the claims costs are no longer eligible for reinsurance payments, between $500,000 and $1 million.

A health carrier becomes eligible for a reinsurance payment when the claims costs for an eligible individual's covered benefits in a benefit year exceed the attachment point, when the health carrier has implemented care management practices for enrollees, and the health carrier makes the request for reinsurance payment. The amount of the payment equals the product of the coinsurance rate and the carrier's claims costs for the individual that exceed the attachment point.

Claims submitted by health carriers for purposes of the reinsurance program are confidential and not subject to public review.

Reinsurance payments to eligible health carriers cannot exceed $200 million for any applicable benefit year. If there are insufficient funds for reinsurance payments, the program must make a pro rata reduction in reimbursement amounts to stay within available funds. If

there are excess funds at the end of a year, the excess funds may be used for contingency funding in addition to reducing the next year's assessment.

Program Assessments. On or before October 1 for 2018, and by May 15 each subsequent year, the Board must determine the covered lives assessment necessary to generate $200 million per year in the upcoming benefit year. Assessments for year one of the program may include an additional 10 percent to be used as contingency funding. The aggregate amount to be raised in any year may be reduced by any surpluses in the program account. Health carriers and third party administrators must all pay the assessment on the lives that they cover, except for lives covered where the federal government is the primary payer, through direct practices, or through health plans with 50 or fewer enrollees. Long-term care, dental, vision, accident, fixed indemnity, disability income contracts, workers compensation, and certain other benefit plans are also exempt from the covered lives assessment.

Each health carrier and third party administrator's assessment is determined by multiplying the total eligible claims by a fraction. The numerator of the fraction equals the carrier or administrator's total number of covered lives. The denominator equals the total number of covered lives in the state. If an assessment against a carrier or administrator is prohibited by court order, the assessment must be assessed against all other carriers and administrators.

Assessments must be paid within 90 days of the carrier or administrator being notified. The Board may abate or defer assessments based on a determination that the assessment would endanger the ability of the carrier or administrator to fulfill its contractual obligations. Late payments or payments on abated or deferred assessments are subject to interest.

Assessments must be deposited in the reinsurance program account.

Third Party Administrator Registration. Third party administrators must register annually with the Commissioner beginning on or before January 1, 2019.

Washington Reinsurance Program Account. The Washington reinsurance program account is created to collect assessments and any federal funds received to support the program. The account must be used to operate the reinsurance program. Appropriations are not required to make expenditures from the account. The account may maintain an initial cash deficit for one fiscal year.

State Innovation Waiver. The Commissioner must apply to the Secretary of Health and Human Services for a state innovation waiver to implement the reinsurance program by April 1, 2018. The Commissioner must make a draft application available for tribal consultation and public review by March 1, 2018. The Commissioner must notify the chairs and ranking members of the House of Representatives and the Senate health care and fiscal committees of any federal actions regarding the waiver request.

Rate Filings. Carriers must calculate the premium amount that would have been charged for the benefit year if the Washington reinsurance program had not been established, and submit this information to the Commissioner as part of rate filing.

Contingent on Federal Waiver. WVA and the Board may not operate the reinsurance program if the state innovation waiver is not approved or not renewed.

Rulemaking. The Commissioner may adopt rules necessary to implement the reinsurance program.

Alternative Financing. The Commissioner must consult with the Office of Financial Management, Department of Revenue, Health Care Authority, and Health Benefit Exchange to study alternative financing mechanisms.

Civil and Criminal Liability. The program, health carriers and third party administrators assessed by the program, officers and employees of the program, and the Commissioner and the Commissioner's representatives and employees are not civilly or criminally liable for any actions taken or not taken in the performance of their powers and duties under the program.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute): Moves the program administration from WSHIP to the Washington Vaccine Association (WVA). Allows the reinsurance board to propose changes to the WVA articles of organization and bylwas. Directs the plan of operation to include procedures for collecting contingency funding and to prevent the double-counting of covered lives. Allows for the program to make pro rata reductions in reimbursement amounts if there are insufficient funds to fund the program. If there are excess funds, those funds may be rolled over to the next year. Covered lives are limited to Washington residents. The administrative costs of the program are capped at 1.5 percent, and appropriations for administrative costs are removed. Allows the 2018 assessment to include contingency funding up to 10 percent of the assessments. Allows assessments to be collected quarterly. Certain dates are changed in the bill. Direct practices, coverage where the federal government is the primary payer, and plans with 50 or fewer lives are exempt from the assessment. The limitation of alternative funding sources to the 2021 through 2023 plan years is removed. The program account is authorized to maintain an initial cash deficit for one fiscal year.

Appropriation: $450,000 from the General Fund for the fiscal biennium ending June 30, 2019 to the Washington reinsurance program; $290,000 for the biennium ending June 30 2019 from the Insurance Commissioner's regulatory account; and $100,000 for the biennium ending June 30, 2019 from the General Fund to the Office of the Insurance Commissioner.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

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

Staff Summary of Public Testimony on Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This reinsurance plan could help stabilize the state's individual insurance market. While it might not guarantee the solution, it would be an important piece to the puzzle. The provider and hospital communities' support for this bill would be contingent on there being no provider tax. There are still concerns that there would be counties with no insurance options, even with the reinsurance bill. This

program manages risk behind the scenes, so nothing with plan offering or plan design changes for the consumer.

OTHER: A state based reinsurance program is an important tool to stabilize the individual market. It will help pay for high cost claims in a predictable manner. Reinsurance is proven to lower premiums, which can also increase enrollment. Carriers have experience with reinsurance programs and this program will utilize federal pass through funds to help offset the costs of administering it. There are some concerns around requiring issuers to bear the burden of paying for the program, when pharmaceuticals, providers and other factors are also cost drivers in the insurance market. This assessment will escalate prices disproportionately. The assessment should be broadened to cover a larger base of entities paying into the fund.

CON: Small businesses, individuals, and association health plans, already pay a large share of the assessments for WSHIP, and this is another narrow tax on these entities to cover a different population. There is no guarantee that each county will have coverage or that health insurance rates will go down. The only guarantee is that this program will add higher costs to policy holders. This is just a mechanism for the carriers to shift their risk.

Persons Testifying: PRO: Senator Annette Cleveland, Prime Sponsor; Mike Kreidler, Washington Office of the Insurance Commissioner; Sean Graham, WSMA; Chris Bandoli, WSHA; Erin Dziedzic, American Cancer Society, Bleeding Disorder Foundation of Washington, Susan G. Komen of Puget Sound; Callie Wilson, RN,MN.

CON: Patrick Connor, National Federation of Independent Business; Tom Kwieciak, Building Industry Association of Washington.

OTHER: Meg Jones, Association of Washington Healthcare Plans; Sheela Tallman, Premera; Zach Snyder, Regence; Melissa Putnam, Kaiser-Washington.

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