

HOUSE BILL REPORT

ESSB 5526

As Passed House - Amended:

April 10, 2019

Title: An act relating to increasing the availability of quality, affordable health coverage in the individual market.

Brief Description: Increasing the availability of quality, affordable health coverage in the individual market.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Frockt, Cleveland, Kuderer, Randall, Keiser, Dhingra, Conway, Wellman, Darneille, Hunt, Hobbs, Das, Lias, Nguyen, Pedersen, Rolfes, Saldaña and Van De Wege; by request of Office of the Governor).

Brief History:

Committee Activity:

Health Care & Wellness: 3/26/19, 4/2/19 [DPA];

Appropriations: 4/6/19, 4/8/19 [DPA(APP w/o HCW)].

Floor Activity:

Passed House - Amended: 4/10/19, 54-38.

Brief Summary of Engrossed Substitute Bill (As Amended by House)

- Requires the Washington Health Benefit Exchange to develop standardized health plans.
- Requires the Health Care Authority to contract with health carriers to offer standardized qualified health plans.
- Requires the Health Care Authority to develop a plan for premium subsidies for individuals purchasing coverage on the Washington Health Benefit Exchange.
- Requires the Insurance Commissioner to submit an annual report on the number of health plans available per county on the individual market.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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.

Majority Report: Do pass as amended. Signed by 9 members: Representatives Cody, Chair; Macri, Vice Chair; Davis, Jinkins, Riccelli, Robinson, Stonier, Thai and Tharinger.

Minority Report: Do not pass. Signed by 3 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers.

Minority Report: Without recommendation. Signed by 1 member: Representative Harris.

Staff: Jim Morishima (786-7191).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care & Wellness. Signed by 19 members: Representatives Ormsby, Chair; Bergquist, 2nd Vice Chair; Robinson, 1st Vice Chair; Cody, Dolan, Fitzgibbon, Hansen, Hudgins, Jinkins, Macri, Pettigrew, Pollet, Ryu, Senn, Springer, Stanford, Sullivan, Tarleton and Tharinger.

Minority Report: Do not pass. Signed by 13 members: Representatives Stokesbary, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Dye, Hoff, Kraft, Mosbrucker, Schmick, Steele, Sutherland and Ybarra.

Staff: Catrina Lucero (786-7192).

Background:

Individual Market Coverage Through the Health Benefit Exchange.

Through Washington's Health Benefit Exchange (Exchange), individuals may compare and purchase individual health coverage and access premium subsidies and cost-sharing reductions. Premium subsidies are available to individuals between 100 percent and 400 percent of the federal poverty level. Cost-sharing reductions are available to individuals between 100 percent and 250 percent of the federal poverty level. Health plans are offered in the following actuarial value tiers: Bronze (60 percent actuarial value), Silver (70 percent actuarial value), Gold (80 percent actuarial), and Platinum (90 percent actuarial value). Federal law allows a variation of 4 percent lower and 5 percent higher for Bronze plans and 4 percent lower and 2 percent higher for Silver, Gold and Platinum plans. Carriers offering coverage on the Exchange must offer at least one Silver and one Gold plan.

Only health plans certified by the Exchange as qualified health plans (QHPs) may be offered on the Exchange. Qualified health plans must be offered by licensed carriers and therefore must meet requirements generally applicable to all individual market health plans, including offering the essential health benefits, having their premium rates reviewed and approved by the Insurance Commissioner, and meeting network adequacy requirements.

Standardized Health Plans.

Standardized health plans are plans that offer coverage subject to specified coverage requirements, such as actuarial values, cost sharing, and benefits. Pursuant to state and federal law, standardized Medicare supplemental insurance plans are offered in Washington. Standardized individual market health plans are offered on the health benefit exchanges in some states, including California, Connecticut, Washington D.C., Massachusetts, Maryland, New York, Oregon, and Vermont, but not in Washington.

Business and Occupation Tax.

Almost all businesses located or doing business in Washington are subject to the state business and occupation (B&O) tax. The B&O tax is imposed on the gross receipts of business activities. Revenues are deposited in the State General Fund.

The classification and rate of the B&O tax is based on the type of business activity. The most common types of activities include retailing, wholesaling, manufacturing, and services and other activities. There are several rate categories, and a business may be subject to more than one B&O tax rate. Certain types of business activities are exempt from the B&O tax.

Summary of Amended Bill:

Standardized Health Plans.

The Exchange, in consultation with the Insurance Commissioner, the Health Care Authority (HCA), an independent actuary, and stakeholders, must establish up to three standardized plans for each of the Bronze, Silver, and Gold actuarial value tiers. The standardized plans must be designed to reduce deductibles, make more services available before the deductible, provide predictable cost sharing, maximize subsidies, limit adverse premium impacts, reduce barriers to maintaining and improving health, and encourage choice based on value, while limiting increases in health plan premium rates. Any data submitted by health carriers to the Exchange for purposes of establishing the standardized benefit plans are exempt from public disclosure, including when the data are held by the Insurance Commissioner when consulting with the Exchange.

Before finalizing the standardized plans, the Exchange must provide notice and a public comment period. The Exchange must provide written notice of the standardized plans for the year by January 31 in the year prior. The Exchange may make modifications to the standardized plans after January 31 to comply with changes to state or federal law or regulations. The Exchange may update the standardized plans annually.

Beginning on January 1, 2021, any health carrier offering a QHP on the Exchange must offer one standardized Silver plan and one standardized Gold plan on the Exchange. If a health carrier offers a Bronze plan on the Exchange, it must offer one Bronze standardized plan on the Exchange. A health carrier offering a standardized plan must meet all requirements relating to QHP certification, including requirements relating to rate review and network adequacy.

Carriers may continue to offer non-standardized plans on the Exchange. A non-standardized Silver plan may not have an actuarial value that is less than the actuarial value of the Silver

standardized plan with the lowest actuarial value. The Exchange, in consultation with the Insurance Commissioner, must analyze the impact to consumers of offering only standard plans on the Exchange beginning in 2025. The report must be submitted to the Legislature by December 1, 2023, and include an analysis of how plan choice and affordability will be impacted for Exchange customers across the state.

State-Procured Qualified Health Plan.

The HCA, in consultation with the Exchange, must contract with at least one health carrier to offer QHPs on the Exchange for plan years beginning 2021. A health carrier contracting with the HCA must offer at least one bronze, one silver, and one gold QHP in a single county or in multiple counties. The goal of the procurement is to have a choice of QHP offered in every county. The HCA may not execute a contract with an apparently successful bidder until the Insurance Commissioner has given final approval of the health carrier's rates and forms and the plans have been certified as QHPs. Data submitted by a health carrier to the HCA as part of the contracting process are exempt from public disclosure.

The QHPs offered pursuant to an HCA contract may use an integrated delivery system or a managed care model that includes care coordination or care management to enrollees as appropriate and must:

- be standardized health plans;
- meet all requirements for QHP certification, including requirements relating to rate review and network adequacy;
- incorporate recommendations of the Bree Collaborative and the Health Technology Assessment Program;
- meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing, including standards for population health management, high value and proven care, health equity, primary care, care coordination and chronic disease management, wellness and prevention, prevention of wasteful and harmful care, and patient engagement;
- employ utilization management processes that meet national accreditation standards, align with criteria published by the HCA, and focus on care that has high variation, high cost, or low evidence of clinical effectiveness; and
- comply with any requirements established by the HCA to address amount expended on pharmacy benefits, including increasing generic utilization and using evidence-based formularies.

The total amount the QHP reimburses providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, may not exceed 150 percent of the total amount Medicare would have reimbursed providers and facilities for the same or similar services in the statewide aggregate. Beginning in 2023, the Director of the HCA, in consultation with the Exchange, may waive this requirement if the HCA determines that selective contracting will result in actuarially sound premium rates that are no greater than the QHP's previous plan year rates adjusted for inflation using the consumer price index.

The QHP's reimbursement rates for critical access hospitals and sole community hospitals may not be less than 101 percent of allowable costs. The QHP's reimbursement rates must be at least 135 percent of Medicare rates for services performed by providers who are not

employees of hospitals or entities affiliated with hospitals or for primary care services designated by the HCA that are performed by physicians with a primary specialty of family medicine, general internal medicine, or pediatric medicine.

The B&O tax does not apply to amounts received by a provider for services performed on patients covered by a QHP offered pursuant to an HCA contract, including reimbursement from the QHP and any amounts collected from the patient as part of his or her cost-sharing obligation.

By December 1, 2022, the HCA, in consultation with the Insurance Commissioner and the Exchange, must submit to the Legislature on the following:

- the impact on QHP choice, affordability, and market stability of linking offering a QHP pursuant to an HCA contract with participation in programs administered by the Public Employees' Benefits Board (PEBB), the School Employees' Benefits Board (SEBB), or the HCA;
- the impact on QHP choice, provider networks, affordability, and market stability of linking provider participation in the networks of QHPs offered pursuant to an HCA contract with participation in provider networks of programs administered by the PEBB, the SEBB, or the HCA; and
- other issues the HCA deems relevant.

Premium and Cost-Sharing Assistance.

The Exchange, in consultation with the HCA and the Insurance Commissioner, must develop a plan to implement and fund premium subsidies for individuals whose modified adjusted gross incomes are less than 500 percent of the federal poverty level and who are purchasing individual market coverage on the Exchange. The goal of the plan must be to enable participating individuals to spend no more than 10 percent of their modified adjusted gross incomes on premiums. The plan must also include an assessment of providing cost-sharing reductions to plan participants and the impact of premium subsidies on the uninsured rate.

The Exchange must submit the plan, along with proposed implementing legislation, to the appropriate committees of the Legislature by November 15, 2020.

Individual Market Plans.

The Insurance Commissioner must submit an annual report to the Legislature on the number of health plans available per county in the individual market.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) This bill is important for the stability of the individual market. It is imperative that the state address affordability. People with low and moderate incomes are paying 30 percent of their incomes on premiums. Out-of-pocket expenses have skyrocketed. These cost increases have inter-generational effects and are causing people to dip into their savings. People are paying for the privilege of paying co-pays and are getting priced out of the market. The prospect of the Patient Protection and Affordable Care Act being repealed is terrifying to people, since most jobs do not include benefits. The state must act now to decelerate these cost increases. This can be done without increasing costs to consumers. For example, insurance company salaries, profits, and other overhead could be reduced.

There are some differences between this bill and the House companion. For example, this bill has language about active purchasing, instead of a rate cap. It also does not include language about medical loss ratios.

A provider rate cap is important—active purchasing and transparency are not substitutes for the cap. Rural providers must receive fair payment, but this must be done without raising costs to enrollees.

The success of this bill depends on broad buy in among stakeholders and the willingness of providers and hospitals to participate. Providers and hospitals, however, do not want to participate in a market where provider rates are suppressed. This bill uses an active purchaser model to drive down costs and does not cap rates. This approach leaves more room for balance and is better than a take-it-or-leave-it rate system.

The standardized plans authorized in this bill move cost-sharing into the premium, which will help high-cost enrollees. It is important for non-standardized plans to continue to be offered. There must also be a review of standardized plans to examine the ripple effect into other market segments. The plan for premium subsidies is a concern.

This state needs a true public option, which would be publicly run and managed by the HCA. This bill currently only affects a fraction of the population and ignores the health needs of the majority of people. A true public option will provide greater assurance that people can access affordable health care. The system can be designed while the state waits for other opportunities.

(Opposed) Health care costs need to be reduced, but an active purchasing model will not do this. States that have tried this model still have high costs, higher uninsured rates, and high deductibles. This bill focuses on premium costs and not on the underlying costs of care. The conversation therefore needs to include a rate cap, which might be at the Medicare rate, be a range, or differ in urban versus rural areas.

(Other) Health insurers provide meaningful benefits to people and are required to have rates that are not excessive or inadequate. Both versions of this bill seek to address affordability through rate suppression. The true beneficiary of this bill is the federal government, which will pay fewer subsidies to Washington consumers. The unintended consequences of this bill will be employers dumping employees into the individual market and the closure of provider networks to Medicare clients. The standardized plans required by this bill should be developed by the Office of the Insurance Commissioner (OIC), which has the expertise to

evaluate the implications across market segments. The OIC would also have to engage in stakeholder engagement through the Administrative Procedures Act rulemaking process. Other states have used approaches that work. Washington should implement standardized plans now and use the interim to develop a strategy for next year.

Staff Summary of Public Testimony (Appropriations):

(In support) Seven-hundred thousand people in Washington are affected by the high cost of insurance premiums. The cost of health care forces people to borrow money.

(Opposed) Creating a public option is an important issue, but this bill is not the appropriate mechanism. The rate setting component proposed in this bill is problematic. Capping rates would affect provider networks. Many providers will not participate if the rates are held to Medicare rates. This bill could destabilize individual and small business markets. Hospitals operate on thin margins. Medicare reimbursement is not sufficient. The active purchaser model contemplated in this bill will not achieve the results legislators are looking for. The Legislature should be looking at the cost of care rather than limiting the rate paid to providers. A reinsurance model would be preferable. This bill could shift costs to the private group market. There will be winners and losers.

Persons Testifying (Health Care & Wellness): (In support) Jason McGill, Office of the Governor; Molly Vorriss, Health Benefit Exchange; Ashley Sutton, Economic Opportunity Institute; Sean Graham, Washington State Medical Association; Patrick Connor, National Federation of Independent Business; Kelly Powers and Marcia Stedman, Health Care for All Washington.

(Opposed) Zach Snyder, Regence Blue Shield; and Len Sorrin, Premera Blue Cross.

(Other) Meg Jones, Association of Washington Healthcare Plans.

Persons Testifying (Appropriations): (In support) Cindi Laws.

(Opposed) Sean Graham, Washington State Medical Association; Andrea Davis, Coordinated Care; Amber Ulvenes, Kaiser Permanente; Chris Bandoli, Washington State Hospital Association; Mel Sorensen, America's Health Insurance Plans; Carrie Tellefson, Regence Blue Shield; and Kathy Gano, Premera Blue Cross.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Appropriations): None.