SENATE BILL REPORT
SB 5526

As Reported by Senate Committee On:
Health & Long Term Care, February 19, 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: Senators Frockt, Cleveland, Kuderer, Randall, Keiser, Dhingra, Conway, Wellman, Darneille, Hunt, Hobbs, Das, Liias, Nguyen, Pedersen, Rolfes, Saldaña and Van De Wege; by request of Office of the Governor.

Brief History:
Committee Activity: Health & Long Term Care: 2/18/19, 2/19/19 [DPS-WM, w/oRec, DNP].

Brief Summary of First Substitute Bill

- 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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5526 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Randall, Vice Chair; Conway, Dhingra, Frockt, Keiser and Van De Wege.

Minority Report: That it be referred without recommendation.

Signed by Senator Rivers.

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.

Minority Report: Do not pass.
Signed by Senators O'Ban, Ranking Member; Bailey and Becker.

Staff: Evan Klein (786-7483)

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 and 400 percent of the federal poverty level. Cost-sharing reductions are available to individuals between 100 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.

The actuarial value refers to the total average costs for covered benefits that the plan will cover. 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 (commissioner), and meeting network adequacy requirements.

Standardized Health Plans. Standardized health plans are plans offering coverage subject to specified 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.

Summary of Bill (First Substitute): Standardized Health Plans. The Exchange, in consultation with the 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 confidential and exempt from public disclosure.

Before finalizing the standardized plans, the Exchange must provide notice and a public comment period. The Exchange must provide written notice to health carriers of the

standardized plans by January 31st of the year prior to the plans being offered. 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 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. 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 offer non-standardized plans on the Exchange as follows:

- a non-standardized silver plan may not have an actuarial value that is less than the actuarial value of the silver standardized plan.
- for plan years 2021 and 2022, a health plan may offer an unlimited number of non-standardized plans.
- for plan years 2023 and 2024, a health plan may offer no more than three non-standardized plans in each of the bronze, silver, and gold levels.
- for plan years beginning 2025, a health plan may offer no more than two non-standardized plans in each of the bronze, silver, and gold levels.

State-Procured Qualified Health Plan. The HCA, in consultation with the Exchange, must contract with at least one health carrier to offer Silver and Gold QHPs on the Exchange for plan years beginning 2021. The QHPs 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;
- use a managed care model; and
- pay fee-for-service provider rates that do not exceed Medicare rates for the same or similar covered service in the same or similar geographic area—for non-fee-for-service reimbursement methodologies, the aggregate amount paid to providers and facilities may not exceed the equivalent of the aggregate amount the QHP would have reimbursed providers and facilities using fee-for-service Medicare rates. The plan must reimburse critical access and sole community hospitals at a rate that is at least 101 percent of allowable costs.

The HCA must use a request for qualifications process to contract with the health carriers. The HCA must review the qualifications of health carriers seeking to offer QHPs and may negotiate with the health plans to the extent necessary to refine the carriers' responses. The HCA must contract with all carriers who meet the minimum qualifications. A health carrier offering a state-procured QHP may continue to offer other health plans in the individual market.

Premium and Cost-Sharing Assistance. The Exchange, in consultation with the HCA and the 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.

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

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Removes the requirement that the standardized silver plan have an actuarial value between 68 and 70 percent.
- Adds a requirement that the QHP offered pursuant to a contract with HCA utilize a managed care model that includes care coordination and care management to enrollees.
- Adjusts the cap on nonstandard plans beginning in 2025 from zero to two, for each of the bronze, silver and gold metal tiers.
- Requires qualified health plans selected by HCA to offer a contracted plan on the individual market, to reimburse critical access hospitals and sole community hospitals at, at least 101 percent of allowable costs.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Original Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This bill is designed to provide individuals health insurance that is meaningful and to address problems on the individual market related to access and affordability. This would address bare counties and would bring down costs in the individual market. Standardized plans could make purchasing coverage easier for every consumer. For the immediate future, this bill is an important step to lay the foundation for health insurance coverage in Washington. There are 300,000 Washingtonians who rely on the individual market, even though it is only 4.4 percent of the total insurance market. While many people are able to stay on their parents insurance until age twenty-six, many are unable to do so, and have to purchase coverage on the Exchange. Options on the Exchange are currently too expensive. The increased transparency laid out in this bill will help consumers choose the appropriate level of coverage. The individual market is both volatile and is a safety net for individuals with no other options. For low and moderate income employees, they can be paying up to 30 percent of their income on premiums. Out of 50 rural hospitals in Washington, 39 are critical access hospitals (CAH), and those CAH's get paid at cost under Medicare rates. Standardizing cost sharing helps reduce deductibles, and helps produce transparent cost-sharing requirements. Washington would join a number of other states in offering standard plans. The only part of the bill that would help reduce premiums, is linking rates to Medicare. Whenever the non-group market goes through changes, there is a potential for effects in the employer sponsored insurance market. Those

anxieties were prominent prior to enactment of the ACA. However, market reforms have not been shown to drastically change employer sponsored health insurance coverage. The price changes in the federal reform and Massachusetts state reforms, led to price decreases larger than what would happen in this bill. Therefore, decreases in enrollment in the employer structure under this bill is not expected. Employers do not jump out of employee coverage due to the tax subsidy for buying employee insurance, which is a significant benefit for attracting workers. Almost all research has shown that a cost-shift between markets does not exist. Decreases in reimbursements in the individual market generally leads to decreases in costs in the other markets, not higher costs. The hope would be to improve this bill by creating a true public option and providing for a workgroup to dialogue with providers on reimbursement rates and best practices. There is support for removing the restriction on actuarial values for silver plans.

CON: This bill will increase costs to employer sponsored health care benefits. Employers continue to cover much of the increased costs in the employer health insurance market, but there is a lot of concern in rising premiums. The bill in the current form will destabilize the employer market, and will limit access to care for Medicaid enrollees. While standardized plans may be good for the state, there is concern that the bill would limit consumer choice. There has not been an opportunity to fully evaluate this idea in this state. This bill may also destabilize the non-public individual health plans that are not offered on the Exchange. It may also lead to issues in rural areas that rely more significantly on revenue from the individual market. Small employers may choose to transition employees into the public option to save money, which may destabilize the small group market as well. This bill might do more harm to small businesses than help. Less than 50 percent of small businesses offer coverage to their employees in Washington because of lack of affordable options for them to purchase. Commercial markets pay more for care than government programs. The cost shifting could destroy the individual market. The current state of the Exchange is stable and working for Grays Harbor County. The state's current approach to health care is all wrong. There are people making decisions about our health care that do not have the peoples' best interests in their heart. This bill is being promoted as a public option, but a public option would not best serve the people of Washington, because it still allows private insurers to be in the individual market. Designing a system that continues to allow insurance companies to work in health care will continue to lead to higher costs than what would be achieved through a universal, single-payer health care system. Single payer health care is working all over the world and would work in Washington.

OTHER: Health care reform is a priority for physicians, including pursuing universal access to care for everyone in the state. The standard plan design, access dynamics, and subsidy model in the bill are good. However, the rate setting at Medicare in the bill does not cover the cost of care and raises concern. If the public option is successful, it may prohibit physicians from seeing as many Medicaid patients. Hospitals are also supportive of coverage expansions in Washington. However, hospitals are also opposed to setting reimbursement rates at the Medicare rates. The overall Medicare reimbursement margin is dropping, and is already negative as compared to actual costs. Medicare rates do not currently cover the actual cost of care. Directing HCA to make all plans standard plans may not be the best approach. Standard plans are commendable, especially for enrollees with high cost needs. However, not all individuals have high health care needs, and may benefit from a lower premium, higher cost-sharing arrangement. There is also concern about the timing around

developing the premium subsidy structure. In 2020, employers will be able to provide HRAs to employees, and allow portability, which may further any market shifting created by this bill.

Persons Testifying: PRO: Senator David Frockt, Prime Sponsor; Janet Varon, Northwest Health Law Advocates; Jason McGill, Office of Governor Inslee; Erica Duke, Patient; Pam McEwan, CEO of the Health Benefit Exchange; Jane Beyer, Office of the Insurance Commissioner; Linda Blumberg, Urban Institute; Dave Knutson, Community Health Plan of Washington; Sue Birch, Director, Health Care Authority; Marcia Stedman, Health Care for All Washington; Cindi Laws, Health Care for All Washington.

CON: Gary Smith, Independent Business Association; Greg Seifert, Washington Association of Health Underwriters; Monica Ewing, National Association of Insurance and Financial Advisors; Thea DeYoung, citizen; Amy Anderson, Association of Washington Business; Meg Jones, Association of Washington Healthcare Plans; Mel Sorenson, America's Health Insurance Plans; Kathryn Lewandowsky, Whole Washington; Jeffery Denton, Whole Washington.

OTHER: Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; Patrick Connor, National Federation of Independent Business; Amber Ulvenes, Kaiser Permanente.

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