SENATE BILL REPORT

ESSB 6067

As Reported By Senate Committee On:
Health & Long-Term Care, February 3, 2000

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

Brief Description: Modifying provisions concerning access to individual health insurance coverage.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senator Thibaudeau).

Brief History:
Committee Activity: Health & Long-Term Care: 4/20/99, 4/21/99 [DPS, DNP]; 1/20/00, 2/3/00 [DP2S].
Passed Senate, 4/24/99, 26-23.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

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

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 not provided coverage by their employer must get insurance in the individual market. Approximately 200,000 to 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 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 ratio 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. However, at the end of this period, carriers began reporting significant individual market losses, and rates began to increase. Within the past year, the three major carriers in the individual market, cited such losses, decided to no longer sell individual plans. Currently, commercial individual coverage is not available to new enrollees in 30 of the state's 39 counties.

The explanation for the market's behavior includes 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 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 the average. But because coverage could no longer be denied by carriers, WSHIP had been essentially dormant since 1993. In the summer of 1999, however, WSHIP eligibility was expanded to allow anyone residing in an area of the state without commercial individual coverage to enroll. It now provides coverage to approximately 1400 people. 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 128,500 persons whose enrollment in the BHP is subsidized, and 3,000 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 Second Substitute Bill: A list of principles which must be adopted in order to establish affordable health insurance for individuals is set forth.

Second Substitute Bill Compared to Engrossed Substitute Bill: The entire content of the engrossed substitute bill is replaced with a list of principles which must be adopted in order to establish affordable health insurance for individuals.

Appropriation: None.

Fiscal Note: Not requested.

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

Testimony: It is crucial that the Legislature act to revitalize the individual insurance market. Consumers and business should not be adversely impacted by any changes adopted. The parties are committed to working on a solution that will pass this session.

Testified: Deborah Senn, Insurance Commissioner; Barb Flye, Washington Citizen Action and Northwest Health Law Advocates; Andrea Stepherson, The Empower Alliance; Trent House, Pam MacEwan, Callie Denton, Jack McRae, Association of Washington Health Care Plans; Lonnie Johns-Brown, National Organization for Women, National Association of Social Workers; John Vipowd, Association of Washington Business; Tanis Marsh, League of Women Voters; Joel Hasting, NW Aids Foundation; Nick Federici, Lung Association; Jim Halstrom, Health Care Purchasers Association, Master Builders of King County.