# HOUSE BILL REPORT
# HB 2355

**As Reported by House Committee On:**
Health Care & Wellness

**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**: Representatives Cody, McBride, Tharinger, Robinson, Ormsby, Appleton and Jinkins; by request of Insurance Commissioner.

**Brief History:**
**Committee Activity:**
Health Care & Wellness: 1/9/18, 1/16/18 [DPS].

**Brief Summary of Substitute Bill**

- Establishes a claims-based reinsurance program for individual market health plans.
- Requires the reinsurance program to collect assessments on behalf of the Washington State Health Insurance Pool.
- Changes the entities subject to assessments for the Washington State Health Insurance Pool to be the same as the entities subject to reinsurance assessments.

## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report**: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 14 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Slatter, Stonier and Tharinger.

**Minority Report**: Without recommendation. Signed by 2 members: Representatives Graves, Assistant Ranking Minority Member; Rodne.

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*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.*

**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 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 they 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.

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.

III. 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 a 10-year budget plan that is budget neutral for the federal government.

IV. The Washington Vaccine Association.

The Washington Vaccine Association (WVA) is a statutorily created nonprofit corporation that collects assessments from most health payors in Washington and sends the funds to the Department of Health (DOH). The DOH uses the funds to purchase vaccines and supplies them to providers at no charge. The WVA is governed by a board representing health carriers, third-party administrators (TPAs), Taft Hartley plans, state employees, physicians, and the DOH.

V. 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.

The WSHIP is funded through premiums and assessments on health carriers, including Medicaid managed care organizations, carriers offering stop-loss plans, and the state's Uniform Medical Plan. The assessment amount is calculated based on the percentage of statewide covered lives enrolled in a carrier's health plans. For stop loss plans and the Uniform Medical Plan, each covered life counts as one-tenth of a life.

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.

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**Summary of Substitute 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 million.

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. The health carrier must submit an attestation describing its care management strategies and committing to offer an enrollee who is the subject of a reinsurance claim the opportunity to participate. 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.

A health carrier eligible for reinsurance payments must submit its claims by April 30 following requirements established by the WRP. Claims data must be drawn from the federal dedicated distributed data environment used for the federal risk adjustment program.

On May 30 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 August 1, 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 million for any benefit year. If reinsurance payments are less than $200 million, the excess must be used for contingency funds or to reduce health carrier assessments for the following year. If reinsurance claims exceed $200 million, the program must make a pro rata reduction in payments necessary to keep reimbursement amounts at or below $200 million. If funds available to pay claims are less than $200 million and are insufficient to fund submitted

claims, the program must make a pro rata reduction in payments to stay within available funds.

II. Program Administration.

The WRP is operated by the Washington Vaccine Association through a separate management board (Board). The Board consists of the following members:

- the Commissioner;
- a member representing small employers;
- a member representing fully insured large employers;
- a member representing self-insured employers;
- a member representing third-party administrators;
- a member representing health carriers offering individual market coverage;
- a member with expertise in reinsurance;
- a member of the Washington Vaccine Association's (WVA's) board of directors; and
- a public member representing consumers who purchase individual market coverage.

The Board has the following powers and duties:

- prepare and propose amendments to the articles of organization and bylaws of the WVA 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, including accountants, actuaries, attorneys, investment advisors, and auditors;
- conduct periodic audits;
- cause the WRP to be audited by an independent certified public accountant;
- 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 15, 2018, the Board must submit the reinsurance plan of operation to the Commissioner for review and approval. The Commissioner must approve the plan on or before June 1. The plan must:

- provide for the operation of the WRP separate from the WVA;
- 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;
- establish the amount of contingency funding necessary to ensure the continued operation of the program, not to exceed 10 percent of gross assessments;
- establish procedures to prevent the double-counting of covered lives in the calculation of the assessment;
- establish a schedule and procedures for health carriers and third-party administrators to submit annual statements and other reports deemed necessary to calculate the assessment; and
- contain additional provisions necessary for the execution of the powers and duties of the WRP.

The Board must contract with an entity to administer the program, including entities under contract with the Board for WVA 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.

Most health carriers and third-party administrators (TPAs) must pay 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. Types of coverage exempt from the assessment include direct practices, coverage offered by carriers or TPAs with fewer than 50 covered lives in Washington, Medicaid, Medicare, and other programs where the federal government is the primary payor.

On or before October 1, 2018, and May 15 in subsequent years, the Board must determine the covered lives assessment for each health carrier and TPA. The assessment is determined in the following manner:

- First, the Board determines the gross assessment, which is $200 million plus anticipated administrative costs not to exceed 1.5 percent of the gross assessment amount. The gross assessment for 2018 may include contingency funds, but subsequent assessments may not.

- Second, the net assessment amount is calculated by subtracting from the gross assessment any federal funds, surplus funds from the previous year, and any other available state or federal funding.
- Third, the health carrier's or TPA's assessment is calculated by multiplying the net assessment by 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 offered by the health carrier or administered by the 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 offered by all health carriers or administered by TPAs during the preceding calendar year.

The Commissioner must approve the assessment by October 15, 2018, and by May 30 in subsequent years. By October 16, 2018, and by June 1 of subsequent years, 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, but may not collect payments more frequently than quarterly.

After notification, the health plan or TPA has 45 days to make its payments, after which interest accrues. The Board may allow a health carrier or TPA in arrears to 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 plus interest. 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.

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

In developing assessment collection procedures, the Board must strongly consider the procedures used in the federal reinsurance program. Health carriers and TPAs must submit annual statements or other reports deemed necessary for the calculation of the assessment to the Board.

The Washington State Health Insurance Pool (WSHIP) must send its assessments to the Board for collection. The Board must add WSHIP assessments to the WRP assessments and remit amounts collected for the WSHIP assessments back to the WSHIP. The Board must work with the WSHIP to synchronize assessment dates for the two programs.

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 WVA.

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.

The Commissioner must post on his or her website any reports submitted to the federal government on the implementation of the waiver.

If the waiver is terminated or not renewed, the reinsurance program may not be operated.

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. 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 until the Legislature has enacted an alternative financing source.

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 nonappropriated 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 Commissioner 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. The Account may maintain an initial cash deficit of no more than one fiscal year to defray its

initial program costs. The Legislature may appropriate funds into the Account to reduce administration costs.

If the reinsurance program is terminated, any funds remaining in the Account, after allowances for remaining program and termination expenses, must be returned to the health carriers and TPAs that paid assessments in the most recent assessment period.

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.

V. The Washington State Health Insurance Pool.

The entities subject to a WSHIP assessment are made the same as the entities subject to a WRP assessment. Third-party administrators are subject to a WSHIP assessment, while Medicaid managed care organizations and stop loss plans are no longer subject to a WSHIP assessment. The requirement that each covered life under Uniform Medical Plan counts as one-tenth of a life is eliminated.

**Substitute Bill Compared to Original Bill**:

The substitute bill:

- changes program administration from the Washington State Health Insurance Pool (WSHIP) to the Washington Vaccine Association through a management board (Board);
- specifies the membership of the management Board;
- adds the following to the reinsurance plan of operation:
    - the amount of contingency funding necessary to ensure continued program operation, not to exceed 10 percent of program assessments;
    - procedures to prevent double-counting covered lives in the assessment calculation; and

        - a schedule and procedures for the submission of information necessary for the assessment calculation;
- requires a health carrier receiving reinsurance payments to submit an attestation describing its care management strategies and committing to allowing enrollees to participate;
- requires reimbursement amounts to be reduced if there is insufficient funding for reimbursement payments;
- allows excess funds to be used for contingency funding, in addition to for assessment reductions;
- makes the following changes to the assessment process:
    - makes the assessments subject to approval by the Insurance Commissioner;
    - limits "covered lives" to Washington residents;
    - eliminates the ability to assess for start-up costs;
    - caps administrative costs at 1.5 percent of assessments;
    - allows initial assessments to include contingency funds;
    - requires the Board to use procedures to prevent double-counting of covered lives when calculating the assessment;
    - prohibits assessments from being collected more than quarterly;
    - requires interest to be collected on late payments or payments that are deferred or abated; and
    - specifically requires carriers and third-party administrators to pay assessments and comply with reporting requirements;
- requires the Washington Reinsurance Program (WRP) to collect assessments levied by the WSHIP and remit those amounts back to the WSHIP;
- modifies or specifies dates for adopting the plan of operation, making reimbursement payments, and making assessments;
- expands the types of plans exempt from assessments to include direct practices, coverage where the federal government is the primary payer, and plans with 50 or fewer enrollees;
- removes the limitation that alternative funding sources be limited to between 2021 and 2023;
- allows the Washington Reinsurance Account (Account) to carry a deficit within a fiscal year;
- requires the Office of the Insurance Commissioner to publish on its website any reports submitted to the federal government on the implementation of the waiver;
- requires the program to be terminated if the waiver is terminated or not renewed;
- specifies the manner in which funds in the Account must be distributed if the WRP is terminated (termination costs first followed by reimbursement to the entities who paid assessments);
- removes the appropriations;
- makes the entities subject to WSHIP assessments the same as entities subject to reinsurance assessments; and
- removes the requirement that each covered life under the Uniform Medical Plan count as one-tenth of a life for purposes of WSHIP assessments.

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**Appropriation**: None.

**Fiscal Note**: Requested on January 4, 2018.

**Effective Date of Substitute Bill**: The bill contains an emergency clause and takes effect immediately.

**Staff Summary of Public Testimony**:

(In support) The individual market in Washington is in jeopardy. Purchasers of individual coverage have someone else helping them pay; they include retirees, part-time workers, self-employed persons, and small business owners. Premium rates in the individual market are on the rise due to a variety of factors, including drug costs, elimination of cost sharing reduction payments, and the elimination of the individual mandate. It is therefore critical to stabilize the individual market. The program in this bill is similar to the federal reinsurance program, which was eliminated in 2016. This program will reduce, but not eliminate premium increases. Federal waiver funds will help fund the program. This is not a giveaway to insurers—every dollar goes to pay claims. This program is expected to lower premium increases by 10 percent. This program must be up and running by 2019. The Washington Vaccine Association should administer this program. This bill supports providers in their practices. This bill does not guarantee there will be no bare counties, but is a good piece of the puzzle. A provider tax should not be used to fund this program. This program will work behind the scenes and be invisible to consumers. Consumers understand reinsurance and think it is a good idea.

(Opposed) This plan is half-baked at best. The reinsurance program created by this bill will not guarantee carriers will offer coverage. This is a wing and a prayer, praying for federal funding and praying that coverage will be offered in every county. Federal funding is not guaranteed. The program should be funded out of the General Fund, not from the people who are already struggling to purchase insurance. There should be a sunset clause to this legislation. The assessment should be on mergers, pharmacy benefit managers, or provider systems. Health carriers are going to pass on these costs. Health carriers that also have a third-party administrator should not get double-billed. The state has already gone through this with the Washington State Health Insurance Pool (WSHIP). The assessment mechanism for the WSHIP is unfair. The WSHIP assessments were supposed to go away, but they have not. It is difficult to assess Taft Hartley trusts and self-insured plans. The fiscal note to this bill should reflect costs to state employees.

(Other) The individual market is unstable due to significant uncertainty, loss of cost sharing reduction payments, the elimination of the individual mandate penalty, and high cost claims. Reinsurance is a proven solution to high cost claims and will lower premiums. High cost claims arise in all sectors of the market, so the funding for the program should be broad-based. It is not fair to place the entire burden on health carriers and larger employers. The funding should not apply to self-funded plans or to coverage for vulnerable populations. As the number of uninsured rises, the entire economy is affected. This type of program has been proven to lower premiums. This state already has experience with the federal reinsurance program, which supported plans with higher risk enrollees, prevented adverse selection, and encouraged plans to cover all types. Other states have already received approval for federal waiver funding.

**Persons Testifying**: (In support) Mike Kreidler and Jane Buyer, Office of the Insurance Commissioner; Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; Eric Dziedzic, American Cancer Society; and Callie Wilson.

(Opposed) Tom Kwieciak, Building Industry Association of Washington; and Patrick Conner, National Federation of Independent Business.

(Other) Meg Jones, Association of Washington Healthcare Plans; Melissa Putman, Kaiser Permanente; Sheela Tallman, Premera Blue Cross; and Zach Snyder, Regence Blue Shield.

**Persons Signed In To Testify But Not Testifying**: None.