SENATE BILL REPORT
SB 6062

As Reported by Senate Committee On:
Health & Long Term Care, January 23, 2018
Ways & Means, January 25, 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].
Ways & Means: 1/24/18, 1/25/18 [DP2S, DNP].

Brief Summary of Second 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)

SENATE COMMITTEE ON WAYS & MEANS

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: That Second Substitute Senate Bill No. 6062 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair; Billig, Carlyle, Conway, Darneille, Hasegawa, Hunt, Keiser, Mullet, Palumbo, Pedersen and Ranker.

Minority Report: Do not pass.

Signed by Senators Braun, Ranking Member; Honeyford, Assistant Ranking Member; Bailey, Becker, Brown, Fain, Rivers, Schoesler, Wagoner and Warnick.

Staff: Sandy Stith (786-7710)

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 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 (Second 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.

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 WAYS & MEANS COMMITTEE (Second Substitute): The carrier and TPA assessment was removed.

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 bylaws. 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: None.

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 (Health & Long Term Care): *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 (Health & Long Term Care): 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 (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: The health insurance marketplaces, including Washington's Health Benefit Exchange, have become an important source for access to health insurance in the country. Unfortunately, federal actions have created instability in the marketplace. Washington experienced a market collapse in the 1990s and must take proactive actions this year to avoid repeating history. The state's individual market covers 300,000 people, who will have nowhere to get coverage if the individual market collapses, other than the state's high risk pool; an expensive option with no way to access federal subsidies. There are currently nine counties with only one health carrier option, and average premiums increased 34 percent in the past year. This bill is not about bailing out insurance companies, it is about stabilizing the market. Alaska, Minnesota and Oregon have all had reinsurance waivers approved by the current administration. Wisconsin is also pursuing a program. This reinsurance program will depress rate increases by 10 percent and ensure every county has coverage options. The funding source for this program is the same as was used for the federal reinsurance program between 2014 and 2016. The attachment point, reinsurance cap, and care management requirement will each help prevent carriers from running up claims costs, by ensuring that carriers must still aggressively manage care. While this program does not guarantee there will not be bare counties and does not guarantee a 10 percent rate reduction, doing nothing will. While an important program, the assessment should be broadened so the full burden of the program is not on a narrow segment of the market.

CON: Taft-Hartley plans were not required to pay the federal reinsurance assessment because of their status as self-insured, self-administered health plans. This exemption status for ERISA and Taft-Hartley funds should similarly apply to the state reinsurance program's assessment. These health funds do not receive any tangible benefit from the reinsurance

program. Taft-Hartley trustees are not opposed to reinsurance, but believe it should be paid for by a per capita fee. Three of the health carriers in the individual market hold roughly $3 billion in surplus reserves, meaning they have funds available to pay for the reinsurance program, yet policy holders are asked to pay $200 million more for reinsurance. Moreover, there are no guarantees this waiver will push down rates or prevent bare counties. This bill would force the cost of stop-loss insurance onto plans that already pay for stop-loss insurance for their own plans.

OTHER: The reinsurance waiver is necessary to attract federal funds, but there is concern that assessing health plans will drive up the expense of the same products that the program is trying to reduce the cost of. Alternative funding mechanisms should be reviewed that are not tied directly to the chain of health care purchasing. Instead, funding could be tied to things that create adverse health conditions. Although temporary, the federal reinsurance program did bring down rates and reinsurance is supported if part of a broader strategy for market stabilization. A broader and more diverse package of revenue options that spreads cost beyond health care purchasers could be used to fund the program. The proponents of the bill should be thanked for ensuring state employees at least pay a full share. However, if the assessment against TPAs and Taft-Hartley trusts is prohibited by court order, the assessment comes back on the rest of us. A null and void clause or a general fund backstop could be used to avoid this issue.

Persons Testifying (Ways & Means): PRO: Senator Annette Cleveland, Prime Sponsor; Erin Dziedzic, ACS CAN, Susan G Komen, Puget Sound Bleeding Disorder Foundation of Washington; Chris Bandoli, Washington State Hospital Association; Sean Graham, Washington State Medical Association; Lonnie Johns-Brown, Office of the Insurance Commissioner; Jane Beyer, Office of the Insurance Commissioner; Courtney Smith, Kaiser Permanente Washington.

CON: Linda Josephson, Taft Hartley attorney; Patrick Connor, NFIB/Washington; Chris McClain, Ironworkers Local 86, Washington Building and Construction Trades.

OTHER: Mel Sorensen, Washington Association of Health Underwriters; Meg Jones, Association Washington of Health Care Plans; Len Sorrin, Premera; Tom Kwieciak, Building Industry Association of Washington.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.