HOUSE BILL REPORT
HB 1523

As Reported by House Committee On:
Health Care & Wellness

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: Representatives Cody, Macri, Riccelli, Stonier, Tharinger, Ormsby, Davis, Frame, Robinson, Thai, Doglio, Stanford and Valdez; by request of Office of the Governor.

Brief History:
Committee Activity:
Health Care & Wellness: 1/30/19, 2/15/19 [DPS].

Brief Summary of 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. 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 4 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers and Maycumber.

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: Without recommendation. Signed by 2 members: Representatives DeBolt and Harris.

Staff: Jim Morishima (786-7191).

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 four percent lower and five percent higher for Bronze plans and four percent lower and two 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 DC, Massachusetts, Maryland, New York, Oregon, and Vermont, but not in Washington.

Summary of Substitute 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 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 of the standardized plans for the year by January 31 in the year prior. 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 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 not offer non-standardized plans on the Exchange.

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 that includes care coordination care management to enrollees as appropriate; 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 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 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.

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

Substitute Bill Compared to Original Bill:

The substitute bill:
- removes the requirement that the standardized Silver plan have an actuarial value between 68 and 70 percent; and
- requires that a QHP offered pursuant to a contract with the Health Care Authority utilize a managed care model that includes care coordination care management to enrollees as appropriate.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill will help patients in the individual market; it is about affordability and stability. The number of uninsured in Washington is historically low, but gaps still remain. Approximately 300,000 Washington residents would be affected by this bill, or approximately 4.4 percent of the insurance market. Many people who purchase coverage on the individual market pay a significant portion of their incomes on premiums and cost sharing; medical costs can be overwhelming. People with tight budgets do not have incomes that are predictable to remain covered. Many have low savings. The gulf between costs and coverage has widened. Because of the high costs, people delay care. Unmet health care needs leave people vulnerable, particularly if they are homeless. Small employers have to choose between providing health coverage and other employee benefits. Freeing people from employer-sponsored coverage frees people to start their own businesses. Medical debt is the number one reason for bankruptcies. Help should be available to people who are doing

the right thing by purchasing coverage. No one should be left behind because they are unable to afford coverage. Fourteen Washington counties only have one insurer offering coverage—this bill will leverage the purchasing power of the state to ensure the entire state is covered. The risk this bill presents to the insurance market is low, when you consider things from a total market perspective. Other solutions should be examined too, but many of them are expensive or require changes to federal law. The Medicare rate cap in this bill is fair—other countries have taken this approach. We cannot keep spending this much money on health care; people need affordable coverage with benefits they can use. The standardized plans required by this bill will help consumers make apples-to-apples comparisons and will simplify and standardize the menu of options. Seven other states have done this. The actuarial value of the Silver standardized plans specified in this bill should be changed—otherwise, the state risks leaving federal funding on the table. The plan for premium subsidies will help people for whom cost is the main barrier. The state should not wait; concrete steps should be taken now. Helping low-income consumers will strengthen the risk pool, since these people tend to be younger and healthier. This bill take an important step toward affordability and quality.

(Opposed) People are happy with coverage in the individual market, which is currently stable. This bill will create a cost shift that will lead to higher costs for employer-sponsored plans. Costs are already going up and employers bear the majority of these costs. This bill will destabilize providers and hospitals and will lead to less access to health care. Providers and hospitals will try to recoup these losses by shifting costs to other lines, including individual market plans that are not the public option. The Medicare rates required in this bill are well below market rates and will have unintended consequences. Providers are already opting out of Medicare because of the rates and this bill will make it hard for insurers to form networks. There are too few doctors and too few facilities. This bill will cause doctors to flee the state. This bill will create incentives to limit access to providers. Small employers will stop offering coverage, which will put more pressure on large group market premiums. These large employers will then release their employees into the individual market. Standardized plans are not a good affordability solution. Plan design flexibility is needed. The impact of standardized plans should be studied and non-standardized plans should be offered. This bill may cause carriers to withdraw from the market. This bill is not a true public option; Medicare is a true public option. The problem with utilizing private insurers is high overhead and benefit denials. Medicare Advantage is run by private insurers, and most Medicare beneficiaries choose traditional Medicare instead.

(Other) The burdens of premiums, deductibles, and out-of-pocket costs are recognized. High quality treatment and coverage should be increased. There should be safe, affordable care with coverage that encourages provider participation. The standardized benefit designs in this bill are a good idea, but not every plan should be standardized. For example, the bill requires standardized plans to maximize subsidies, but not every purchaser of coverage receives subsidies. Hospitals have made many contributions to increasing access to affordable care. Hospitals are the safety net, but many have margins that are less than healthy. The Medicare rates in this bill will not be sufficient to cover the costs of hospitals and other providers and will lead to a cost shift to other markets. The lower rates may also lead to decreased provider participation in other programs, including Medicaid, and narrower networks. It can be difficult for small employers to find coverage for their employees. This bill will have detrimental impacts on costs and quality and will threaten affordable coverage,

including employer-sponsored coverage. The bill could lead to the collapse of the fully insured market and a loss of jobs and wage cuts in the health care sector. This needs more scrutiny by experts. People should be given the option to buy into coverage provided to state employees. This bill does not go far enough. A public option should be non-profit and open to all, including members of Indian tribes. Universal coverage is what is needed, not more for-profit health plans. Most people want a government-sponsored, single payer system. This bill will actually do harm by diverting resources away from the necessary work that needs to be done. It condones and validates the for-profit system, which is morally wrong. The for-profit system is confusing and difficult to navigate. Insurance company profits are a huge drain on affordability and broader coverage. Washington needs a universal health care system that is funded by all based on ability to pay. Canada did this province by province. Washington should be the Saskatchewan of the United States. This can be done incrementally, so federal waivers should not be a barrier.

Persons Testifying: (In support) Jason McGill, Office of the Governor; Erica Duke; Jed Whittaker; Mark Stensager, Don Connant, and Pam McEwan, Health Benefit Exchange; Dow Constantine, King County; Janet Varon, Northwest Health Law Advocates; Gary Renville, Project Access Northwest; Carrie Glover; Leanne Berge, Community Health Plan of Washington; and Jane Beyer, Office of the Insurance Commissioner.

(Opposed) Amy Anderson, Association of Washington Business; Meg Jones, Association of Washington Healthcare Plans; Mel Sorenson, America's Health Insurance Plans; Monica Ewing, National Association of Insurance and Financial Advisors; Greg Seifert, Washington Association of Health Underwriters; and Bruce Davidson.

(Other) Chris Bandoli, Washington State Hospital Association; Sean Graham, Washington State Medical Association; Patrick Connor, National Federation of Independent Business; David Grossman, Kaiser Permanente; Georgia Davenport, Washington State Democratic Central Committee; Jennifer Nye; Jane Grafton; Pamela Dalan; and Kathleen Randall.

Persons Signed In To Testify But Not Testifying: None.