HOUSE BILL REPORT
ESSB 5526

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: Senate Committee on Health & Long Term Care (originally sponsored by 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 Care & Wellness: 3/26/19, 4/2/19 [DPA].

Brief Summary of Engrossed Substitute Bill
(As Amended by Committee)

- 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.
- Requires the Insurance Commissioner to submit an annual report on the number of health plans available per county on the individual market.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 9 members: Representatives Cody, Chair; Macri, Vice Chair; Davis, Jinkins, Riccelli, Robinson, Stonier, Thai and Tharinger.

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 3 members: Representatives Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers.

Minority Report: Without recommendation. Signed by 1 member: Representative 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 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, 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 D.C., Massachusetts, Maryland, New York, Oregon, and Vermont, but not in Washington.

Summary of Amended 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 continue to offer non-standardized plans on the Exchange. A non-standardized Silver plan may not have an actuarial value that is less than the actuarial value of the Silver standardized plan with the lowest actuarial value. The Exchange and the Insurance Commissioner must analyze the impact to consumers of offering only standard plans on the Exchange beginning in 2025. The report must be submitted to the Legislature by December 1, 2023, and include an analysis of how plan choice and affordability will be impacted for Exchange customers across the state.

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 may use a managed care model that includes care coordination or care management to enrollees as appropriate and 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;
- meet additional participation requirements to reduce barriers to maintaining and improving health and align to state agency value-based purchasing, including standards for population health management, high value and proven care, health equity, primary care, care coordination and chronic disease management, wellness and prevention, prevention of wasteful and harmful care, and patient engagement;
- employ utilization management processes that meet national accreditation standards, align with criteria published by the HCA, and focus on care that has high variation, high cost, or low evidence of clinical effectiveness;
- have medical loss ratios that meet or exceed 90 percent; 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, after consulting with the Exchange, must conduct procurement negotiations with health carriers and selectively contract with a health carrier or carriers to offer a qualified health plan or plans that offer the optimal combination of choice, affordability, quality, and service. A health carrier contracting with the HCA may offer a QHP or QHPs in a single county or in multiple counties. The goal of the procurement is to have health carriers contracting with the HCA to offer at least one QHP in every county in the state.

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.

Individual Market Plans.

The Insurance Commissioner must submit an annual report to the Legislature on the number of health plans available per county in the individual market.

Amended Bill Compared to Engrossed Substitute Bill:

The amended bill:
- removes the requirement that the Insurance Commissioner review proposed standardized plans;
- removes the requirement that HCA-contracted QHPs reimburse critical access hospitals and sole community hospitals at 101 percent of allowable costs;
- removes the requirement that the HCA consider factors proposed by health carriers with the goal of reducing premiums below 2019 levels;
- requires HCA-contracted QHPs to 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 methodologies, the aggregate provider reimbursement amount may not exceed the equivalent of the aggregate amount the QHP would have reimbursed using fee-for-service rates;
- requires a HCA-contracted QHP to have a 90 percent actuarial value; and
- allows a carrier contracting with the HCA to offer health plans in a single county or in multiple counties.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) This bill is important for the stability of the individual market. It is imperative that the state address affordability. People with low and moderate incomes are paying 30 percent of their incomes on premiums. Out-of-pocket expenses have skyrocketed. These cost increases have inter-generational effects and are causing people to dip into their savings. People are paying for the privilege of paying co-pays and are getting priced out of the market. The prospect of the Patient Protection and Affordable Care Act being repealed is terrifying to people, since most jobs do not include benefits. The state must act now to decelerate these cost increases. This can be done without increasing costs to consumers. For example, insurance company salaries, profits, and other overhead could be reduced.

There are some differences between this bill and the House companion. For example, this bill has language about active purchasing, instead of a rate cap. It also does not include language about medical loss ratios.

A provider rate cap is important—active purchasing and transparency are not substitutes for the cap. Rural providers must receive fair payment, but this must be done without raising costs to enrollees.

The success of this bill depends on broad buy in among stakeholders and the willingness of providers and hospitals to participate. Providers and hospitals, however, do not want to participate in a market where provider rates are suppressed. This bill uses an active purchaser model to drive down costs and does not cap rates. This approach leaves more room for balance and is better than a take-it-or-leave-it rate system.

The standardized plans authorized in this bill move cost-sharing into the premium, which will help high-cost enrollees. It is important for non-standardized plans to continue to be offered. There must also be a review of standardized plans to examine the ripple effect into other market segments. The plan for premium subsidies is a concern.

This state needs a true public option, which would be publicly run and managed by the HCA. This bill currently only affects a fraction of the population and ignores the health needs of the majority of people. A true public option will provide greater assurance that people can access affordable health care. The system can be designed while the state waits for other opportunities.

(Opposed) Health care costs need to be reduced, but an active purchasing model will not do this. States that have tried this model still have high costs, higher uninsured rates, and high deductibles. This bill focuses on premium costs and not on the underlying costs of care. The

conversation therefore needs to include a rate cap, which might be at the Medicare rate, be a range, or differ in urban versus rural areas.

(Other) Health insurers provide meaningful benefits to people and are required to have rates that are not excessive or inadequate. Both versions of this bill seek to address affordability through rate suppression. The true beneficiary of this bill is the federal government, which will pay fewer subsidies to Washington consumers. The unintended consequences of this bill will be employers dumping employees into the individual market and the closure of provider networks to Medicare clients. The standardized plans required by this bill should be developed by the Office of the Insurance Commissioner (OIC), which has the expertise to evaluate the implications across market segments. The OIC would also have to engage in stakeholder engagement through the Administrative Procedures Act rulemaking process. Other states have used approaches that work. Washington should implement standardized plans now and use the interim to develop a strategy for next year.

Persons Testifying: (In support) Jason McGill, Office of the Governor; Molly Vorris, Health Benefit Exchange; Ashley Sutton, Economic Opportunity Institute; Sean Graham, Washington State Medical Association; Patrick Connor, National Federation of Independent Business; Kelly Powers and Marcia Stedman, Health Care for All Washington.

(Opposed) Zach Snyder, Regence Blue Shield; and Len Sorrin, Premera Blue Cross.

(Other) Meg Jones, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.