SENATE BILL REPORT
E2SHB 1523

As Reported by Senate Committee On:
Health & Long Term Care, April 1, 2019

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: House Committee on Appropriations (originally sponsored by Representatives Cody, Macri, Riccelli, Stonier, Tharinger, Ormsby, Davis, Frame, Robinson, Thai, Doglio, Stanford and Valdez; by request of Office of the Governor).

Brief History: Passed House: 3/08/19, 57-41.
Committee Activity: Health & Long Term Care: 3/20/19, 4/01/19 [DPA-WM, w/oRec].

Brief Summary of Amended Bill

- Requires the Washington Health Benefit Exchange to develop standardized health plans.
- Requires the Health Care Authority (HCA) to contract with health carriers to offer standardized qualified health plans.
- Requires the HCA to develop a plan for premium subsidies for individuals purchasing coverage on the Washington Health Benefit Exchange.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.
Signed by Senators Cleveland, Chair; Randall, Vice Chair; O'Ban, Ranking Member; Conway, Dhingra, Frockt, Keiser, Rivers and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senators Bailey and Becker.

Staff: Evan Klein (786-7483)

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.

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 and 400 percent of the federal poverty level. Cost-sharing reductions are available to individuals between 100 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.

The actuarial value refers to the total average costs for covered benefits that the plan will cover. 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 (commissioner), and meeting network adequacy requirements.

Standardized Health Plans. Standardized health plans are plans offering coverage subject to specified 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.

Summary of Amended Bill: Standardized Health Plans. The exchange, in consultation with the commissioner, the 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 to health carriers of the standardized plans by January 31st of the year prior to the plans being offered. 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 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 with the lowest actuarial value. The exchange and the 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 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; and
- 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.

The QHP may use a managed care model. HCA must consider the rates, utilization management policies, pharmaceutical costs, and other factors proposed by the carrier or carriers, with the goal of negotiating for plans that reduce premiums below the average premiums for plans in the same metal tiers in Washington during the 2019 plan year.

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

EFFECT OF HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Directs the commissioner to annually review the standardized plan designs and provide written comments to the exchange and the chairs of the Senate and House of Representatives health care committees.
- Removes the ability for qualified health plans contracting with HCA to be offered in a single county.
- Removes the requirement that the qualified health plans contracting with HCA have a medical loss ratio of at least 90 percent.
- Removes the requirement that the qualified health plans contracting with HCA reimburse providers and facilities at a rate that does not exceed the Medicare rates.
- Directs HCA to consider the rates, utilization management policies, pharmaceutical costs, and other factors proposed by the carrier or carriers, with the goal of negotiating for plans that reduce premiums below the average premiums in Washington during plan year 2019.
- Removes the null and void clause.

Appropriation: The bill contains a null and void clause requiring specific funding be provided in an omnibus appropriation act.

Fiscal Note: Available. New fiscal note requested on March 13, 2019.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony on Engrossed Second Substitute House Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This is a true bipartisan effort to fix issues in the individual market. The goal is to make the market more stable and more affordable. This market is a small slice of the entire health insurance population, but the individual market is the only choice for hundreds of thousands of individuals in the state. Costs have increased in the individual market, and this proposal is a method within current federal and state law to reduce costs without a large expense to the state. There is need to work on what rate works for consumers and providers. People are paying 30 percent of their income on health insurance costs. A rate cap would meaningfully reduce premiums for customers, and even though this rate cap is controversial, there is no reasonable substitute for affordability to a rate cap. Negotiated rates will not reduce expenses to consumers. This bill could be amended to add a true public option to this bill. The population on the individual market equals 22 of the smallest counties in the state. The state cannot afford to ignore these populations in these rural counties. Washingtonians are sick

and tired of haggling over healthcare. The individual market cannot wait to receive affordable health coverage. If the profit motive of insurers is removed, there may be money to be found to spend on the public option. Capping reimbursement rates and medical loss ratios is the only way to drive down costs. The top earning executives in Washington earned $43 million in 2018. The industry can reign in its costs without harming consumers and their families. This bill will also decrease the money the state spends on uncompensated care.

CON: There is support for lowering the cost of the individual market, and for setting up standardized plans. There is a concern that health carriers could not build networks through contracting at Medicare rates, and there is concern that the small group market could collapse as a result of this public option. By increasing the reimbursement rate in the bill, it would be possible to avoid small employer dumping, while still lowering costs. A rate cap of some sort is required to reduce costs, but it needs to be higher than what is in the bill. It needs to be at a level that is sustainable for health plans and consumers. The medical loss ratio in the bill will also be problematic, and should be left at the 80 percent MLR in the Affordable Care Act. Since the bill also suppresses premiums, it compounds the issues for carriers. Allowing for non-standardized plans will allow for consumer choice, and should be left in the bill. The unintended consequences of this bill, make the system unaffordable for health carriers. It is recommended that standard plans be adopted, while spending more time to review data about standing up a health plan. There is concern about the employer costs associated with this bill. The Medicare rate cap is subject to the whims of the federal budgeting process. Low provider rates will require carriers to cost-shift to the individual market. The better bill is SB 5526, that attempts to drive premium reductions in a more collaborative and sustainable manner. An active purchaser model would allow for the state to develop a plan that is better for health plans and better for consumers.

Persons Testifying: PRO: Cindi Laws, Health Care for All Washington; Marcia Stedman, Health Care for All Washington; Jason McGill, Governor's Office; Pam McEwan, CEO, Health Benefit Exchange; Ashley Sutton, Economic Opportunity Institute.

CON: Melissa Putman, Kaiser Permanente; Leonard Sorrin, Premera Blue Cross; Carrie Tellefson, Regence Blue Shield; Meg Jones, Association of Washington Healthcare Plans; Mel Sorenson, Americas Health Insurance Plans; Amy Anderson, Association of Washington Business; Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: No one.