SENATE BILL REPORT
ESSB 5526

As Amended by House, April 10, 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: 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 & Long Term Care: 2/18/19, 2/19/19 [DPS-WM, w/oRec, DNP].

Ways & Means: 2/27/19, 2/28/19 [DPS (HLTC), DNP, w/oRec].

Floor Activity:

Passed Senate: 3/13/19, 36-13.

Passed House: 4/10/19, 54-38.

Brief Summary of Engrossed First 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.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5526 be substituted therefor, and the substitute bill do pass and be referred to 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.

Signed by Senators Cleveland, Chair; Randall, Vice Chair; Conway, Dhingra, Frockt, Keiser and Van De Wege.

Minority Report: That it be referred without recommendation.
Signed by Senator Rivers.

Minority Report: Do not pass.
Signed by Senators O'Ban, Ranking Member; Bailey and Becker.

Staff: Evan Klein (786-7483)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.
Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Billig, Carlyle, Conway, Darneille, Hasegawa, Hunt, Keiser, Liias, Palumbo, Pedersen and Van De Wege.

Minority Report: Do not pass.
Signed by Senators Braun, Ranking Member; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant Ranking Member, Capital; Bailey, Becker, Schoesler, Wagoner, Warnick and Wilson, L..

Minority Report: That it be referred without recommendation.
Signed by Senator Rivers.

Staff: Sandy Stith (786-7710)

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 Engrossed First Substitute Bill: Standardized Health Plans. The Exchange, in consultation with the 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 Insurance Commissioner must annually review the standardized plan designs and provide written comments to the exchange and the chairs of the Senate and House health care committees by January 1st of the year prior to the plans being offered. 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 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 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 Insurance Commissioner must submit an annual report to the Legislature on the number of health plans available per county in the individual market.

Appropriation: None.

Fiscal Note: Available.

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

Effective Date: Ninety days after adjournment of session in which bill is passed.

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 bill is designed to provide individuals health insurance that is meaningful and to address problems on the individual market related to access and affordability. This would address bare counties and would bring down costs in the individual market. Standardized plans could make purchasing coverage easier for every consumer. For the immediate future, this bill is an important step to lay the foundation for health insurance coverage in Washington. There are 300,000 Washingtonians who rely on the individual market, even though it is only 4.4 percent of the total insurance market. While many people are able to stay on their parents insurance until age twenty-six, many are unable to do so, and have to purchase coverage on the Exchange. Options on the Exchange are currently too expensive. The increased transparency laid out in this bill will help consumers choose the appropriate level of coverage. The individual market is both volatile and is a safety net for individuals with no other options. For low and moderate income employees, they can be paying up to 30 percent of their income on premiums. Out of 50 rural hospitals in Washington, 39 are critical access hospitals (CAH), and those CAH's get paid at cost under Medicare rates. Standardizing cost sharing helps reduce deductibles, and helps produce transparent cost-sharing requirements. Washington would join a number of other states in offering standard plans. The only part of the bill that would help reduce premiums, is linking rates to Medicare. Whenever the non-group market goes through changes, there is a potential for effects in the employer sponsored insurance market. Those anxieties were prominent prior to enactment of the ACA. However, market reforms have not been shown to drastically change employer sponsored health insurance coverage. The price changes in the federal reform and Massachusetts state reforms, led to price decreases larger than what would happen in this bill. Therefore, decreases in enrollment in the employer structure under this bill is not expected. Employers do not jump out of employee coverage due to the tax subsidy for buying employee insurance, which is a significant benefit for attracting workers. Almost all research has shown that a cost-shift between markets does not exist. Decreases in reimbursements in the individual market generally leads to decreases in costs in the other markets, not higher costs. The hope would be to improve this bill by creating a true public option and providing for a workgroup to dialogue with providers on reimbursement rates and best practices. There is support for removing the restriction on actuarial values for silver plans.

CON: This bill will increase costs to employer sponsored health care benefits. Employers continue to cover much of the increased costs in the employer health insurance market, but there is a lot of concern in rising premiums. The bill in the current form will destabilize the employer market, and will limit access to care for Medicaid enrollees. While standardized plans may be good for the state, there is concern that the bill would limit consumer choice. There has not been an opportunity to fully evaluate this idea in this state. This bill may also destabilize the non-public individual health plans that are not offered on the Exchange. It may also lead to issues in rural areas that rely more significantly on revenue from the individual market. Small employers may choose to transition employees into the public option to save money, which may destabilize the small group market as well. This bill might do more harm to small businesses than help. Less than 50 percent of small businesses offer coverage to their employees in Washington because of lack of affordable options for them to purchase. Commercial markets pay more for care than government programs. The cost shifting could destroy the individual market. The current state of the Exchange is stable and working for Grays Harbor County. The state's current approach to health care is all wrong.

There are people making decisions about our health care that do not have the peoples' best interests in their heart. This bill is being promoted as a public option, but a public option would not best serve the people of Washington, because it still allows private insurers to be in the individual market. Designing a system that continues to allow insurance companies to work in health care will continue to lead to higher costs than what would be achieved through a universal, single-payer health care system. Single payer health care is working all over the world and would work in Washington.

OTHER: Health care reform is a priority for physicians, including pursuing universal access to care for everyone in the state. The standard plan design, access dynamics, and subsidy model in the bill are good. However, the rate setting at Medicare in the bill does not cover the cost of care and raises concern. If the public option is successful, it may prohibit physicians from seeing as many Medicaid patients. Hospitals are also supportive of coverage expansions in Washington. However, hospitals are also opposed to setting reimbursement rates at the Medicare rates. The overall Medicare reimbursement margin is dropping, and is already negative as compared to actual costs. Medicare rates do not currently cover the actual cost of care. Directing HCA to make all plans standard plans may not be the best approach. Standard plans are commendable, especially for enrollees with high cost needs. However, not all individuals have high health care needs, and may benefit from a lower premium, higher cost-sharing arrangement. There is also concern about the timing around developing the premium subsidy structure. In 2020, employers will be able to provide HRAs to employees, and allow portability, which may further any market shifting created by this bill.

Persons Testifying (Health & Long Term Care): PRO: Senator David Frockt, Prime Sponsor; Janet Varon, Northwest Health Law Advocates; Jason McGill, Office of Governor Inslee; Erica Duke, Patient; Pam McEwan, CEO of the Health Benefit Exchange; Jane Beyer, Office of the Insurance Commissioner; Linda Blumberg, Urban Institute; Dave Knutson, Community Health Plan of Washington; Sue Birch, Director, Health Care Authority; Marcia Stedman, Health Care for All Washington; Cindi Laws, Health Care for All Washington.

CON: Gary Smith, Independent Business Association; Greg Seifert, Washington Association of Health Underwriters; Monica Ewing, National Association of Insurance and Financial Advisors; Thea DeYoung, citizen; Amy Anderson, Association of Washington Business; Meg Jones, Association of Washington Healthcare Plans; Mel Sorenson, America’s Health Insurance Plans; Kathryn Lewandowsky, Whole Washington; Jeffery Denton, Whole Washington.

OTHER: Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; Patrick Connor, National Federation of Independent Business; Amber Ulvenes, Kaiser Permanente.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: We just had a report today from the Health Benefit Exchange on the individual market. For the first time in its history, we have declining enrollment. At the same time, we are seeing skyrocketing premiums and high deductibles. Waiting longer is not an option. We tried to do

reinsurance last year and that did not work. We need to do something soon to help those on the individual market. There is very little general fund impact. There is some for contracting. The proposal does not fund subsidies. It funds a plan for subsidies. This is what we can do now without a huge outlay of funds. There are 14 counties with only one plan to choose from. Many of these people are paying upwards of 30 percent of their income for insurance. The individual market is a safety net for people with no options. In 2017, there were 320,000 people in the individual market. In 2018, that number is down to 260,000. We hope that is in part to a stronger economy and people getting employment, but we know it is in part to the high cost. The funds for the insurance commissioner are from our regulatory account and are to make sure rates are actuarially sound and networks are adequate. The Exchange has about 80 percent of Washington's individual market. We were hit hard by elimination of the federal mandate and reinsurance. This year we saw significant drops in new enrollees, younger enrollees, and an overall decrease of four in the market. This bill takes important steps toward addressing affordability and quality. There is a need for this from the patient and consumer side. There are about 260,000 people in the individual market and there is no other place for them to buy insurance. One-hundred twenty thousand have a deductible of over $6,000. Seventy thousand have a deductible of over $9,000. These are not catastrophic plans. The problem is not just premiums. It is that people are not accessing care because of their high deductibles. We also support the standardized plan design. The average employer plan has a deductible of $1,500. PEB is $750. We do not expect to match that. We just hope to get closer. We want to address sustainability. This bill would provide a first step to making our state more productive by making our citizens healthier and able to hold down jobs and able to pay taxes. It would save the state money by having more productive citizens. We have provided amendments. We would advocate for a work group that would look at review the public option, rates, and access. There are currently twice as many people who are uninsured as are in the individual market. This is not sustainable. We already pay for the uninsured. We see this every year with bills to bail out the rural hospitals and with people who call 911 because they did not get the care they needed. It is a lot more fiscally responsible to do this as a public option to fill the gap. This is not a new idea. The Basic Health Plan used to fill this gap.

CON: We do not object to the objective of the bill. We are not opposed to affordability. We are convinced this is not the right solution. If the bill is successful and premiums go down, there will be a reduction in state revenue related to a reduction in premium tax. The overall market would be destabilized by releasing people into the individual market. The fully insured market would end up releasing their insured people into this market. Large group market insurers could also potentially use their HSA premium dollars to release those individuals who would be unsubsidized into this market. This market has capped rates. This would make it hard to form a network. If a network has diminished capacity, it will not be better for the people it is trying to help. Our biggest concern is that premiums will go down in this one segment of the insurance market, but that has to be made up in another. The premiums in employer plans will increase. Our biggest concern is that we do not know how much this will cost the state. Our concern is that without knowing the cost first, business will bear the cost.

OTHER: We recognize the burden high out of pocket costs have on consumers. We support the standardized plan. We have concerns about the public option. The individual market is about 4 percent of the market, but for Kaiser Permanente, this is a much larger share. By

providing reduced rates, this will cause a large impact. Health care is a priority as is insurance reform. However, we are opposed to the rate setting component. Generally, Medicare does not cover the cost of care. There may be impacts that have been noted to other markets. This may also impact access. There are other approaches that may work and we are committed to working on this. Medicare only covers about 80 percent of the cost of care in a hospital. This will jeopardize the financial stability of some hospitals. Our concern is that individual providers do not have an incentive to stay in the market. We want to make sure there is a true public option available.

Persons Testifying (Ways & Means): PRO: Senator David Frockt, Prime Sponsor; Jason McGill, Governor's Office; Pam McEwan, CEO, Washington Health Benefit Exchange; Jane Beyer, Office of the Insurance Commissioner; Erin Dziedzic, Bleeding Disorder Foundation of Washington; Cindi Laws, Health Care for All Washington; Marcia Stedman, Health Care for All Washington.

CON: Meg Jones, Association of Washington Healthcare Plans; Amy Anderson, Association of Washington Business.

OTHER: Amber Ulvenes, Kaiser Permanente; Sean Graham, Washington State Medical Association; Chris Bandoli, Washington State Hospital Association; Bevin McLeod, NAACP Seattle King County.

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

EFFECT OF HOUSE AMENDMENT(S):
Standardized Plans.
- Permits the Exchange to modify standardized plans based on changes to state and federal law.
- Makes data submitted by health carriers to the Exchange exempt from the Public Records Act, instead of being both confidential and exempt from the Public Records Act.

Qualified Health Plans.
- Requires health carriers contracting with HCA to offer at least one bronze, silver, and gold QHP.
- Permits procured QHPs to be offered in a single county or in multiple counties.
- Changes the goal of the procurement to having a choice of QHP in every county in the state instead of having contracted carriers in every county in the state.
- Prohibits HCA from executing a contract with a health carrier until after the OIC and the Exchange perform the requirements necessary for QHP certification.
- Allows contracted QHPs to use an integrated delivery system.
- Requires contracted QHPs to comply with HCA requirements relating to pharmacy benefits, including increasing generic utilization or use of evidence-based formularies.
- Exempts data submitted by health carriers for purposes of the procurement from the Public Records Act.

Provider Rates.

- Prohibits the total amount a procured QHP reimburses providers and facilities in the statewide aggregate, excluding pharmacy benefits, from exceeding 150 percent of the total amount Medicare would have reimbursed for the same or similar services.
- Allows, beginning in 2023, the HCA to suspend the provider rate limit if it finds that selective contracting will lead to actuarially sound premium rates that increase at a rate no greater than the rate of inflation calculated using the consumer price index.
- Requires primary care services and services performed by a health care provider who is not employed by a hospital or entity affiliated with a hospital, to be reimbursed at no less than 135 percent of the Medicare rate.
- Removes the requirement that the HCA consider factors proposed by health carriers with the goal of reducing premiums below 2019 levels.
- Creates a business and occupations tax exemption for amounts received by a health care provider for services performed on patients covered by a contracted QHP, including reimbursement from the QHP and any amounts collected from the patient as part of their cost sharing obligation.

Studies and Reports.

- Requires the Exchange to consult with OIC when studying the impact of offering standard plans on the Exchange, instead of requiring a joint study.
- Requires HCA, in consultation with OIC to study the impact of linking HCA-contracted QHPs with participation in public health programs administered by PEBB, SEBB, and HCA.
- Requires the Exchange's premium subsidy plan to include an assessment of the impact of premium subsidies on the uninsured rate.
- Adds a null and void clause.