

Prevention Alliance

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Background:

Going into the 2018 legislative session there was widespread uncertainty around the individual health insurance market. Throughout 2017, Congressional Republicans and President Trump continued to state their intent and pursue ‘repealing and replacing’ the Affordable Care Act. These attempts included:

- Congressional consideration of multiple bills that would repeal or significantly modify various components of the Affordable Care Act (none of these ultimately passed).
- President Trump signing an Executive Order that directs federal agencies to allow the interstate sale of association health plans and extend the length of coverage of short-term insurance policies.
- President Trump announcing he is ending Cost-Sharing Reductions (CSR) payments.
- Congress passing, and President Trump signing, the Tax Cuts and Jobs Act that effectively repeals the individual mandate starting in 2019.

These attempts, whether they were successful or not, created uncertainty among consumers, insurance companies, providers, and health systems. This uncertainty in market stability led to large premium rate increases for the 2018 filings, two counties in Washington almost having no health plan options (known as bare counties) until the Insurance Commissioner intervened, nine Washington counties only having one plan offering in 2018, and some carriers pulling out of the individual health insurance market completely.

This instability generated significant interest in finding solutions from state officials including several legislators, the Office of the Insurance Commissioner (OIC), and the Health Benefit Exchange (HBE). This interest has led to a large number of bills being in play during the 2018 legislative session that attempt to address issues that can be grouped into three main categories: market stabilization, creating a public option, and creating a state backstop to various parts of the Affordable Care Act.

Market Stabilization

After the 2018 plan filings had two bare counties until the OIC intervened, there was widespread concern about the growing instability of the individual health insurance market in Washington. Insurance Commissioner Mike Kreidler initiated an effort to explore different [market stabilization options](#). After the release of the [Individual Health Insurance Market Stabilization Analyses](#) report Wakely, a third party actuarial consulting firm, the OIC focused on

establishing a claims-based reinsurance program. Under this program, carriers would submit to the program administrator claims that exceed a set amount or attachment point up to a set cap. The program would reimburse the carrier the appropriate amount based on the established coinsurance rate. Reinsurance is seamless to consumers. People with high-cost conditions enroll in their health plan the same as anyone else. The difference is that when their claims reach a set amount, the reinsurance program reimburses the carrier for that cost. Wakely estimates premiums would be up to 10% lower for all people who purchase coverage in the individual market (not just those whose claims are covered by reinsurance) than they would be without a reinsurance program. It is important to clarify that the rates will not lower by 10% from current filings. Rather, it is estimated that the rates will be 10% lower than they would have been without the reinsurance program. For example, if a carrier would have increased rates by 25% in 2019 without a reinsurance program, it is still estimated that they would go up 15% in 2019 with the reinsurance program.

The cost of the reinsurance program in Washington is estimated to be about \$200 million per year. The OIC planned to submit a [1332 waiver](#) to CMS, which has the potential to draw down federal funds to help implement the program. In order to meet the timeline for applying for and getting approval of a 1332 waiver in time to impact 2019 rate filings, legislation authorizing the OIC to create the program and apply for a 1332 waiver needed to be signed by the Governor by the beginning of February according to the OIC.

OIC-request legislation was pre-filed for the 2018 session: [HB 2355](#) and [SB 6062](#). As introduced, these bills established a claims-based reinsurance program for individual market health plans with the following parameters:

- The attachment point was required to be between \$75,000 and the reinsurance cap.
- The coinsurance rate was required to be between 50-80%.
- The reinsurance cap was required to be between \$500,000 and \$1,000,000.
- Reinsurance payments to eligible health carriers may not exceed \$200 million for any benefit year.

Under the legislation, funding for the reinsurance program involved both the requirement that OIC apply for a 1332 waiver to draw down some federal funds that would cover a portion of the \$200 million needed for the program, and also new assessments would be placed on health carriers and third-party administrators (TPAs).

Each bill was amended in committee in various ways. Most notably, the Senate Ways & Means committee removed the funding mechanism (a health carrier and TPA assessment) from [SB 6062](#), and the House Health Care and Wellness committee amended [HB 2355](#) to require the reinsurance program to collect assessments on behalf of the Washington State Health Insurance Pool (WSHIP) and makes the entities subject to assessment from WSHIP the same as the entities subject to assessment by the reinsurance program, removes the exemptions from WSHIP assessments and subjects the Uniform Medical Plan to a full assessment instead of a 1/10 assessment.

While both bills initially progressed rapidly through their respective committees, neither passed off the floor in time to meet the deadline stated by the OIC for when the legislation needed to pass in order to meet the tight timeline to apply for a federal 1332 waiver in time to impact 2019 rate filings.

Even though the time appears to have passed to apply for a federal 1332 waiver for the 2019 filings, the legislation could be deemed necessary to implement the budget and there may still be potential interest in pursuing a reinsurance program that does not go through the 1332 process and is instead funded by other means, at least for 2019. The funding mechanism will continue to be central to any reinsurance program discussions and the path forward for funding will be challenging given both the health carrier and TPA assessments drew intense scrutiny as the bills progressed through committee.

Public Option

Another area of discussion to address bare counties and slim plan offerings looked to establishing some type of public option in Washington.

[HB 2408](#), sponsored by Representative Cody, was originally introduced in an effort to address bare counties where no health insurance plans are offered. In its original form, HB 2408 would address this issue by requiring a health carrier offering a health plan approved by the School Employees' Benefits Board (SEBB) to offer a qualified health plan (QHP) in counties where no qualified health plans are offered on the Health Benefit Exchange. It also included tax credits to reduce the premiums for enrollees in the Washington State Health Insurance Pool (WSHIP) in counties where there is no other individual market coverage option available. The bill was amended both in committee and on the House floor. As passed off the House floor, the bill now does the following:

- ***Required plan offerings:*** Requires a health carrier to offer silver and gold qualified health plans (QHPs) in counties where it offers a health plan approved by either the School Employees' Benefits Board (SEBB) or the Public Employees' Benefits Board (PEBB). It previously was only tied to the SEBB, but now hooks onto the PEBB as well.
- ***Permitted cross-county purchasing:*** Requires a health carrier and the Health Benefit Exchange (HBE) to allow an individual to purchase an individual market health plan outside of their county of residence if:
 1. There are no individual market health plans, other than catastrophic plans, offered in the individual's county of residence, and
 2. The health plan is offered in the same [geographic rating area](#) as the individual's county of residence.

This requirement is in place until December 31, 2019

- **Network adequacy for plans with cross-county enrollees:** Requires the OIC to take into account the availability of telemedicine services when evaluating network adequacy of a health plan that has enrollees who do not reside in the county in which the health plan is offered *if* the carrier did not participate in the individual market in 2018 in that county. OIC must also consider all reasonable requests to allow the delivery of services using all access points in neighboring counties. This requirement is in place until December 31, 2019.
- **Regarding WSHIP eligibility:** Makes an individual who is eligible to purchase a health plan outside of their county of residence ineligible for coverage by WSHIP. This requirement is in place until December 31, 2019.
- **Prohibition on including certain costs in rates:** Prohibits PEBB and SEBB health plans from including in the rates any administrative costs or actuarial risks associated with a QHP the carrier offers. (HCA is to do annual actuarial reviews ensuring compliance with this prohibition).

The premium tax credits for enrollees in WSHIP in bare counties was removed in the striker amendment.

In this form, the bill passed unanimously off the House floor on February 14th.

Affordable Care Act – State Backstop

There are several bills in play during the 2018 session that are aimed at creating a state backstop for the Affordable Care Act.

- **No cost sharing for preventive services:** [HB 1523](#), which was introduced during the 2017 session, would require health plans to cover, with no cost sharing, all preventive services required that were covered under federal law as of December 31, 2016. Essentially this bill puts into state statute the preventive services provision of the Affordable Care Act, including the requirement that these services be covered without any cost sharing. The bill passed off the House floor with a vote of 56-38. The bill had a hearing in Senate Health & Long Term Care on February 15th and is currently awaiting further action.
- **Individual mandate:** As originally introduced, [SB 6084](#) would have required maintenance of minimum essential health care coverage. In other words, this bill would have established an individual mandate at the state level since it has been repealed at the federal level. While the original bill included language stating individuals were required to have health insurance coverage, it did not include an enforcement mechanism. Establishing an enforcement mechanism is particularly challenging in Washington state because there is no state-level income tax. The federal individual mandate was able to be enforced because if a person did not comply with the law, they would be fined via their federal income taxes. Because Washington does not have a

state income tax (and is prohibited from having one under the state constitution), that cannot be used as the enforcement mechanism. In order to start working towards a solution, the bill was amended in committee to add a task force to explore individual mandate enforcement mechanisms and the feasibility of other options to incentivize the maintenance of minimum essential coverage. The task force is to report its findings to the legislature by December 1, 2018. When brought to the Senate floor, the bill was further amended to completely remove the individual mandate and also changed the bill title to “An Act Relating to Exploring Enforcement of a Requirement to Maintain Minimum Essential Health Care Coverage.” As passed off the Senate floor, the bill would only put in place the task force and required report. The bill passed off the Senate floor with a vote of 25-23 along party lines.

- **Health Benefit Exchange federal references:** The Health Benefit Exchange has request legislation to align statutes with current practice and update references to federal law. In essence, the bill removes all reference to the Affordable Care Act found in current Exchange statutes and instead reference ‘applicable federal law.’ Of significance relating to navigators, which are groups who help enroll people in coverage through the Exchange, this bill puts the actual language from the Affordable Care Act defining ‘navigators’ into state statute rather than referencing applicable federal law. This is the only piece that is specifically written out to put into state statute. Other components of the bill include repealing and consolidating responsibilities that were only needed to establish the Exchange, requiring members of the Exchange Board to serve until a successor has assumed office following the expiration of their term, and builds out the current statute that allows an assessment of insurers to made only in the event that funds are insufficient to fund exchange operations at the level authorized by the legislature for the following calendar year to add three months of additional operating costs. The House version ([HB 2516](#)) passed off the House floor with a vote of 58-40. The Senate version ([SB 6376](#)) did not pass by cutoff, so the House version is the vehicle at this point in session.

Prepared for the Prevention Alliance by:

Carrie Glover

Carrie Glover Consulting

carrie@carriegloverconsulting.com

For more information about the Prevention Alliance, contact:

Julie Peterson

Senior Director of Policy

Foundation for Healthy Generation

juliep@healthygen.org

