New Regulatory Approaches to Health Care Affordability

Northwest Health Law Advocates CLE
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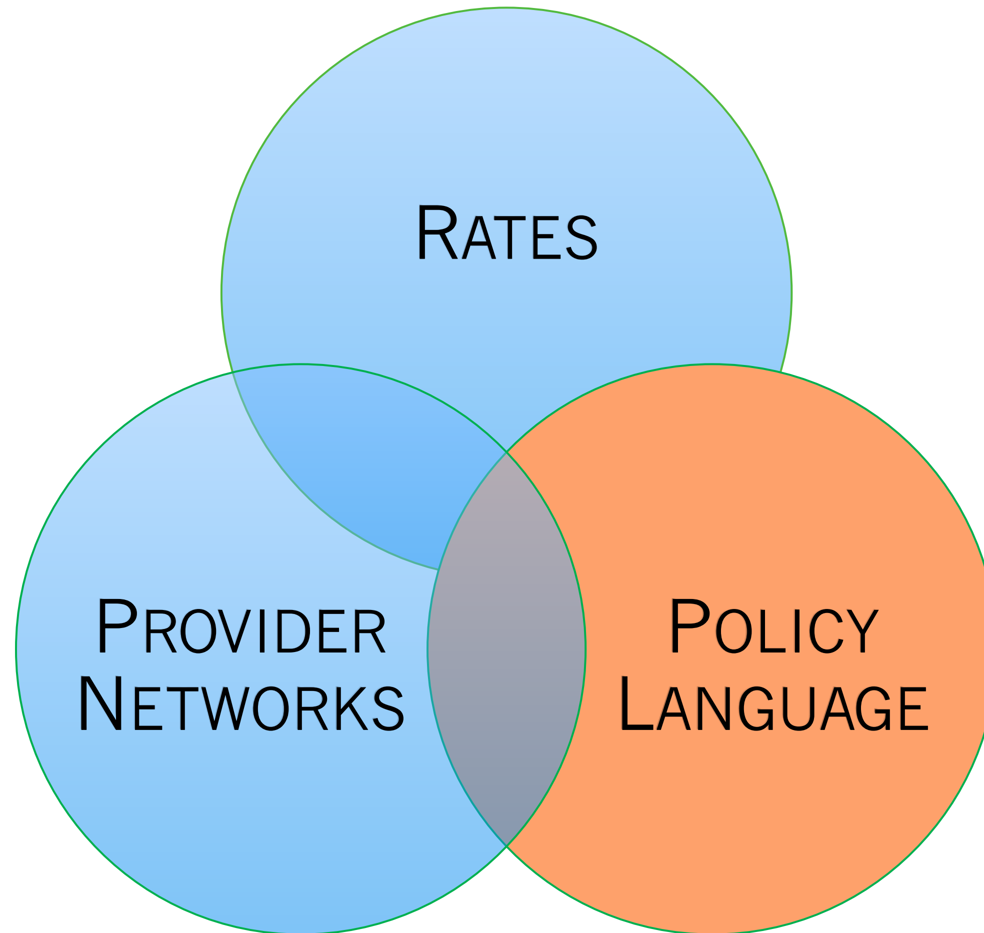
OFFICE of the
INSURANCE
COMMISSIONER
WASHINGTON STATE

2024 individual and small group plan rates

OIC REVIEW – INDIVIDUAL AND SMALL GROUP HEALTH PLANS



OIC Rate review authority

- Prior approval of rates limited to individual and small group health plans
  - Large Group Health Plan rates can be negotiated per RCW 48.43.733(2); no review of reasonableness or prior approval of these rates

- Statutory authority
  - Individual Health Plans: RCW 48.18.110(2), RCW 48.44.020(3), RCW 48.46.060(4), and Affordable Care Act (ACA)
  - Small Group Health Plans: RCW 48.19.010(2), RCW 48.44.040, RCW 48.46.060(6), and ACA

Rates must be actuarially sound

- Individual and SG rates must be approved if actuarially sound
- Rates must be reasonable in relation to the benefits provided
- Individual and small group health plans must meet all Affordable Care Act (ACA) rating requirements, as well as other state and federal requirements.
- Single risk pool for the individual market; single risk pool for the small group market

Rate Projection

For individual and small group plans, insurers must submit detailed calculations and justification to show that proposed rates are actuarially sound and meet all rating requirements

Components of (future prediction of) premium:

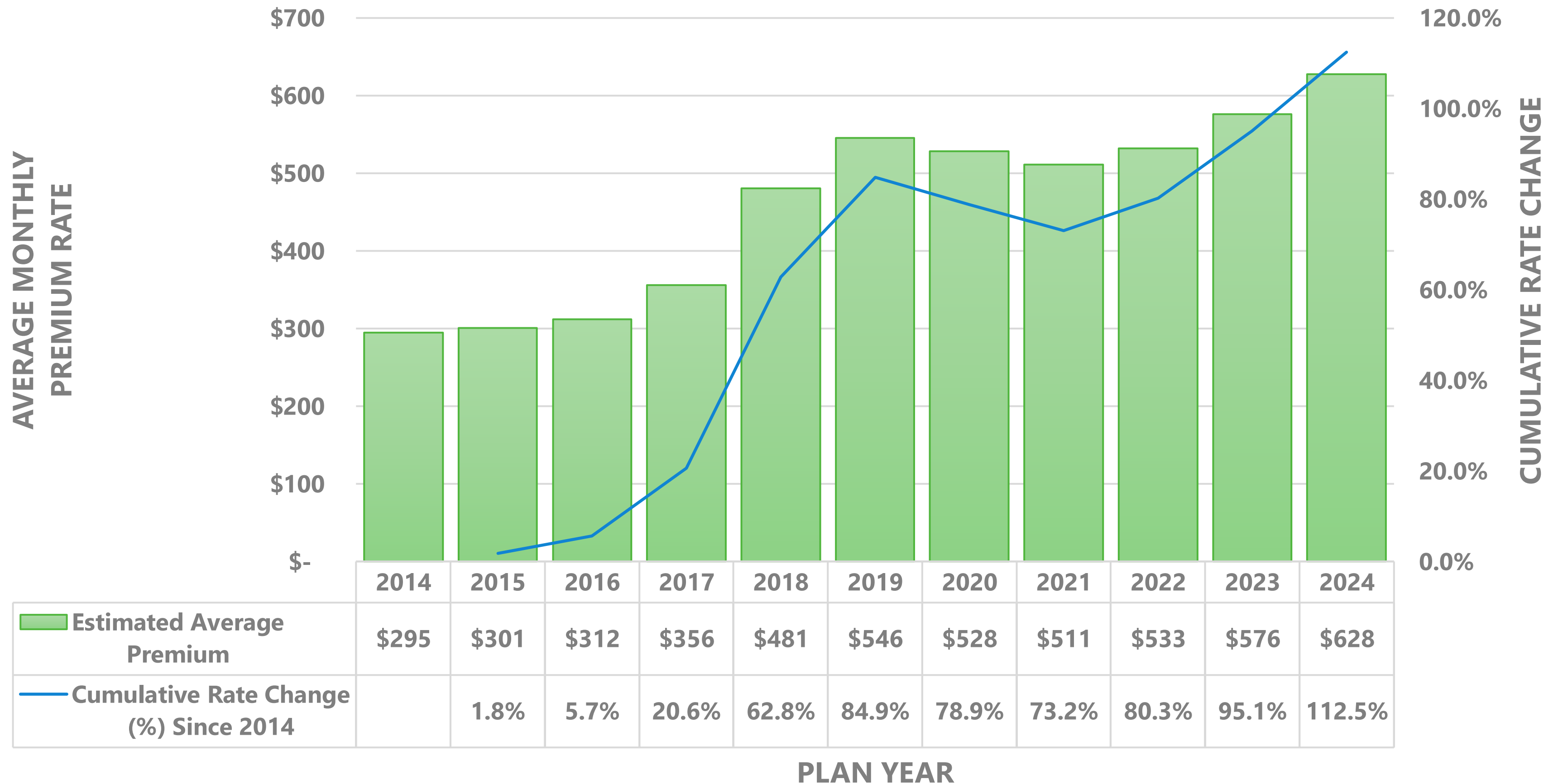
- Medical Claims: Medical trend is combined impact of utilization of health services and changes in price.
    - For plan year 2024, rate projections are based on the past experience of calendar year 2022 and predicted to future premiums in 2024.

Rate Projection, con't

- Administrative Expenses: Expenses not related to paying medical claims.

- Profit or loss/contribution to surplus: 1-4% of premium. Considerations:
  - Company's current surplus level
  - Type of plan, e.g. some plan designs attract more sick people and therefore take on more risk.

Cumulative impact of rate changes



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Estimated Average Premium	$295	$301	$312	$356	$481	$546	$528	$511	$533	$576	$628
Cumulative Rate Change (%) Since 2014		1.8%	5.7%	20.6%	62.8%	84.9%	78.9%	73.2%	80.3%	95.1%	112.5%

2024 Individual Health Plans Requested and Approved Average Rate Changes

Company Name	Exchange Status	Requested Average Rate Change	Approved Average Rate Change	People Impacted[1]
Asuris Northwest Health	Off Exchange	-3.39%	-7.03%	1,057
BridgeSpan Health Company	On Exchange	15.15%	16.35%	1,092
Coordinated Care Corporation	On Exchange	5.24%	4.92%	56,003
Community Health Plan of Washington	On Exchange	2.50%	-1.21%	6,735
Kaiser Foundation Health Plan of the Northwest	Both	8.81%	7.29%	7,799
Kaiser Foundation Health Plan of Washington	Both	17.90%	17.81%	54,253
LifeWise Health Plan of Washington	On Exchange	7.81%	7.79%	25,955
Molina Healthcare of Washington, Inc.	On Exchange	6.41%	6.50%	41,112
PacificSource Health Plans	Both	7.15%	8.49%	3,917
Premera Blue Cross	On Exchange	15.83%	17.20%	13,786
Providence Health Plan	Off Exchange	4.69%	4.69%	228
Regence BlueShield	Both	4.54%	4.40%	22,776
Regence Blue Cross Blue Shield of Oregon	Both	6.51%	8.40%	5,146
UnitedHealthcare of Oregon, Inc.	Both	2.76%	-0.47%	4,370
Total				**244,229**

Exchange Issuers Average Rate Change	
Requested:	**9.11%**
Approved:	**8.94%**

Footnotes

1. The number of people impacted is the most recent available number of enrollees (usually March enrollment of the prior year) from the rate filings.

Cost drivers behind PY 2024 rates

Cost Drivers:

- Increases in the price and utilization of health care services including pent-up demand for elective surgeries and prescription drug costs (including off-label).
- Increases in administrative costs (such as inflation).
- Changes to what payments insurers are either owed or received under the ACA risk adjustment program –
  - Stabilizes the market by spreading financial risk across all insurers. Requires federally collected funds be redistributed from plans with lower-risk enrollees to plans with higher-risk enrollees.
- Whether the insurer has high risk enrollees who incur high dollar claims.

Affordability Study

Legislative directive

Budget proviso (ESSB 5187, Sec. 144(13)) directs OIC, in collaboration with the Attorney General's office, to undertake a health care affordability study.

- OIC contracting with Health Management Associates (HMA) to prepare the report
- Office of the Attorney General: focus on merger and acquisition and anti-competitive contracting issues/options

Legislative directive

- Preliminary report: due to Legislature Dec. 1, 2023
  - Structure of "business of health care" in Washington, i.e. horizontal consolidation, vertical integration, physician employment and private equity acquisitions
  - Overview of policy options to address affordability, including adoption/experience in other states and authority/capacity to adopt in Washington
- Final report: due to Legislature August 1, 2024
  - Deeper actuarial and economic analysis of subset of policy options presented in preliminary report

Range of policy options to be explored

Broad

- Global Budgeting: MD, PA (rural hospitals)
- Health Care Cost Transparency boards/commissions: MA, RI, OR, Nevada, NJ, CA
- Price caps/reference pricing: RI, MT, OR
- Facility fee charge or payment limitations (CN, Medicare)
- Enhanced health plan and public program rate regulation (RI)

Targeted -- Individual and/or Small Group Market

- Public option: WA, CO, NV
- Reinsurance: multiple states
- Exchange subsidies: WA, NM, CA, CO

Ground Ambulance Balance Billing

Legislative directive

OIC report to Legislature by October 1, 2023: How balance billing for ground ambulance services can be prevented. RCW 48.49.190

- Ground ambulance services are the remaining gap in balance billing protections in Washington & nationally
- Complex system:
    - 478 licensed EMS agencies; 299 provide transports
    - Large majority are public entities; public and private providers partner in many jurisdictions
    - Vast differences in staffing, capacity, organization

Key takeaways:

- Consumers' average potential ground ambulance balance bill is more than $500 for emergency services and $1,000 for non-emergency services
- Public and private ground ambulance providers partner to provide care. Public providers respond to emergency 911 dispatches and private providers often provide transport
- Funded by varied mix of public (Medicare and Medicaid, local levies) and private health plan revenue
- Ground ambulance providers contend that balance billing is used to cover some of the disparities between their costs and payment for Medicaid and Medicare patients and for services that are not reimbursed

Recommendations

1. Prohibit balance billing of consumers for emergency and non-emergency transports
2. Reimburse emergency ground ambulance services at a local jurisdiction's fixed rate or, if no local rate exists, at the lesser of a fixed percentage of Medicare or billed charges – with review of rate trends over time and report back to legislature
3. Mandate coverage for emergency transportation to alternative sites, i.e., behavioral health emergency/crisis service facilities

Key findings

1. Uncompensated “treat but no transport” services, i.e., emergency responses that do not result in patient transport to a hospital ED
    - Undertake actuarial analysis of the cost and cost offsets of covering this service, with findings to the 2026 Legislature
2. Maintain supplemental public funding for public and private providers for Apple Health (Medicaid) ground ambulance services
3. Undertake study of EMS an as essential health service provided by local and state governments and funded by federal, state, and/or local funds

Essential health benefits benchmark plan update

Essential health benefits under the ACA

Under the Affordable Care Act, each state must designate an EHB "benchmark plan" to serve as a benchmark, i.e., minimum coverage, for all individual and small group health plans offered in the state

RCW 48.43.715 -- largest small group plan in the state by enrollment as the EHB benchmark plan

- Regence BlueShield Regence Direct Gold+ small group plan.

Designated EHB benchmark plan has not changed since 2012

EHB benchmark plan update option

Final 2019 HHS Notice of Benefits and Payment Parameters gives states an opportunity to update their EHB benchmark plans for years 2020 and beyond

If a state meets the requirements in the federal rules, including the "typicality" and "generosity" tests, benefits added to the state EHB through this EHB benchmark plan selection process meet the definition of EHB and are exempt from the ACA defrayment requirement

Legislative directive

Legislature directed OIC to undertake EHB benchmark plan update in SSB 5338 (2023)

- Report to Legislature due December 31, 2023
- If OIC proceeds with proposed update, submit to CMS by May 1, 2024
- If submitted and approved, new EHB benchmark plan is effective January 1, 2026

WA OIC

Benefits to be reviewed

Must determine potential impacts on plan design, actuarial value, and premium rates if these services were included in the EHB benchmark plan:

- Hearing instruments and associated services
- Fertility services
- Biomarker testing
- Contralateral prophylactic mastectomies
- Donor human milk
- Treatment for pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDA)
- MRI for breast cancer screening

Actuarial analysis underway. Next public meeting October 20, 2023

Questions?

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