Meeting Summary

# Health Insurance Reform Commission

May 6, 2019, at 1:00 p.m.

Pocahontas Building, House Committee Room

dls.virginia.gov/commissions/hir

The Health Insurance Reform Commission (the HIRC) conducted its first meeting of the 2019 interim in Richmond with Delegate Kathy J. Byron, chair, presiding. A quorum of six legislative members was present.[1] Copies of materials presented at the May 6 meeting are accessible through the *HIRC website*.

The duties of the HIRC include monitoring the work of federal and state agencies in implementing the provisions of the federal Patient Protection and Affordable Care Act (ACA); assessing the implications of the ACA's implementation on residents, businesses, and the general fund of the Commonwealth; considering the development of a comprehensive strategy for implementing health reform in Virginia; recommending health benefits required to be included within the scope of the essential health benefits provided under health insurance products offered in the Commonwealth; assessing proposed mandated benefits and providers; conducting other studies of mandated benefits and provider issues as requested by the General Assembly; and developing recommendations to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth.

The meeting was structured to provide members with background information useful in the development of a work plan. The members unanimously re-elected Delegate Byron to serve as the HIRC chair. The vacancy of vice-chair of the HIRC, triggered by the resignation of Senator Frank W. Wagner, was filled by the election of Senator Ryan T. McDougle.

## Presentation: State of the Commonwealth's Insurance Marketplace

*Julie Blauvelt, Deputy Commissioner of the Life and Health Division at the Bureau of Insurance (BOI)*

Ms. Blauvelt provided the HIRC with information on health care coverage in Virginia, premium rates over time in the individual and small group markets, carrier participation, and the effects of various options on the individual market.

A snapshot of Virginians' care coverage in 2018 shows that employer-sponsored plans cover more than half of Virginians, with the majority of these plans (three million lives; 35 percent of the total) covered by self-funded employer-sponsored coverage. State insurance regulation of

[1] Members Present: Delegate Kathy J. Byron (chair), Delegate R. Lee Ware, Delegate David E. Yancey, Delegate Eileen Filler-Corn, Senator Rosalyn R. Dance, Senator Ryan T. McDougle, Commissioner of Insurance Scott White, a nonvoting ex officio member
Members Absent: Senator Richard L. Saslaw, Senator William M. Stanley, Jr., and Secretary of Health and Human Resources Daniel Carey

such self-funded coverage is preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA).

The other major sources of health care coverage in 2018, with the corresponding percentage of covered Virginians, in declining order are:

- Large employer insurance plans (1,148,370 lives; 14 percent)
- Medicare (14 percent)
- Medicaid, including the Children's Health Insurance Program (CHIP), and excluding those made eligible for coverage by Medicaid expansion (12 percent)
- Other public programs, including persons covered by the military and U.S. Department of Veterans Affairs programs (seven percent)
- Small employer insurance plans (351,779 lives; four percent)
- Individual insurance plans (347,087 lives; four percent)

In addition, 10 percent of Virginians were determined to be uninsured in 2018.

Data provided by Ms. Blauvelt disclosed trends in health care coverage over an 11-year period. Between 2008 and 2018, the percentage of Virginians with employer-sponsored coverage (ERISA plans, large employer plans, and small employer plans) declined from 59 percent to 53 percent. The percentage of Virginians covered by non-group (e.g., individual coverage) plans during this period was five percent in 2008, rose to eight percent in 2015, then fell to four percent in 2018. The percentages of Virginians covered under public plans increased over the period, with those covered by Medicaid rising from nine percent to 12 percent, by Medicare rising from 11 percent to 14 percent, and by other public plans from four percent to seven percent. Meanwhile, the percentage of uninsured Virginians, which ranged between 12 and 13 percent from 2008 through 2013, has hovered within a range of nine percent to 10 percent throughout the period 2014 through 2018.

Coverage through health care policies sold in the individual market over the period that the Affordable Care Act (ACA) health benefit exchange has been operational in the Commonwealth jumped from 416,161 in 2014 to 494,086 in the following year, but since then has declined as premiums have increased, with enrollment for 2019 projected to be 293,100. Over the same period, coverage through health care policies sold in the small group market has proven to be much less volatile, with the number of covered lives ranging within a comparatively narrow band of a high of 405,032 (in 2015) and a low of 351,779 (in 2018).

Part of the anticipated decline by 2019 in the number of Virginias covered under plans sold in the individual market may be due to Medicaid expansion. Ms. Blauvelt reported that an actuarial study estimates that between 44,300 and 70,400 individuals will move from the individual market to Medicaid over the next one to three years. Estimates of the effect of Medicaid expansion on the number of persons covered through the individual market range from zero to 2.3 percent. Based on the experiences in other states, it is expected that about 50 percent of Virginians who may be eligible for Medicaid coverage based on an income not exceeding 138 percent of the federal poverty level will become enrolled in Medicaid over the next three years. The BOI has worked with the Department of Medical Assistance Services to address issues

involving persons who become ineligible for subsidies to assist in purchased coverage through the ACA exchange when they become eligible for coverage under Medicaid.

Another explanation for the anticipated decline between 2015 and 2019 of over 200,000 in the number of Virginians covered through individual health plans is the increasing cost of individual coverage on the ACA market. The weighted average premium for such plans was $322 per month in 2014. Over the next three years, average monthly premiums increased at rates of 2.75 percent, 18.83 percent, and 10.03 percent. However, in 2018 average premiums jumped by 69.10 percent (from $433 to $732), and for 2019 they are expected to rise 8.71 percent (from $732 to $796). The rate of increase for 2020 is expected to be relatively small. Nevertheless, average monthly premiums will have doubled in the three years between 2016 and 2019. Comparing actual enrollment in individual ACA coverage to the weighted average premiums for corresponding years indicates a correlation between a spike in cost and a drop in the number of persons covered through such policies.

Regarding the anticipated decline in the number of Virginias covered under plans sold in the individual market, Ms. Blauvelt noted that most of the persons leaving the individual market are not eligible for subsidies through the exchange. An estimated 45,000 will obtain Medicaid coverage. She is not sure where the others are going, because the number of uninsured persons is projected to stay about the same. However, she noted that many may be obtaining coverage in the small group market as a result of legislation enacted in the 2018 Session that opened up the small group market to self-employed individuals and certain single-owner business entities.

With regard to the number of carriers in the individual market, Ms. Blauvelt reported that the number of carriers offering coverage on the exchange and outside the exchange dropped from 14 in 2017 to eight in 2018, and for 2019 that number increased by one. Another carrier is projected to start offering coverage on the exchange in 2020. Corresponding data for the small group market shows greater stability, with the number of carriers offering coverage on the SHOP exchange and off the exchange declining from 18 in 2016 and 2017 to 16 in each of the three succeeding years.

Forty-eight percent of Virginia's localities have one carrier offering plans in the individual market; 42 percent of localities have two carriers; five percent of localities have three carriers; and five percent of localities—all of which are in or adjacent to Fairfax County—have four carriers.

New coverage options, including short-term limited-duration plans and small group coverage sold to sole proprietors, are projected to provide coverage for fewer Virginians than those gaining coverage under the Medicaid expansion. It is assumed that the persons who continue to purchase individual coverage on the exchange are less healthy than those who bought coverage on the exchange in prior years. However, it is also assumed that the morbidity of the individual market is likely to increase as self-employed individuals migrate to the small group market but to decrease as healthy unsubsidized persons purchase short-term limited-duration coverage.

## Mandated Benefits and Essential Health Benefits

Commencing with the 2020 plan year, states have been able to request approval to change the scope of benefits provided under coverage purchased in the individual and small group markets. Currently, Virginia's base-benchmark plan is an Anthem small group plan. The option of

adjusting the benefits mandated under policies offered in these markets prompted a review of mandated benefits and essential health benefits (EHBs).

The application of state and federal laws mandating coverage for certain benefits depends on several factors, including whether coverage is under a self-funded employer plan or a fully-insured plan, whether an employer providing insurance coverage is in the large group or small group, and whether a plan qualifies as a grandfathered plan.

If Virginia opts to revise its benchmark plan, and thereby adjust requirements for coverage of the ACA-required EHBs, it has several options. It may select an EHB benchmark used by another state; it may replace a category of EHBs from the current benchmark with a category used by another state's benchmark; it may choose its own EHBs within parameters; or it may submit options through a waiver under § 1332 of the ACA that provide at least as many individuals with access to affordable and comprehensive coverage.

## Mandated Review Process

*Van Tompkins, Policy Advisor at the BOI*

Ms. Tompkins provided the Commission with a review of the procedure by which it is directed to review legislation that seeks to establish a new mandate for coverage of a health benefit or provider. When such a bill is referred to the HIRC by the chairman of the House or Senate Commerce and Labor Committee, the BOI is directed to conduct a Step 1 Assessment of the measure. A Step 1 Assessment considers the extent to which a proposed mandated health insurance benefit is currently available from qualified health plans in Virginia and whether the proposed mandate exceeds the scope of the EHBs. The issue of whether a mandated benefit exceeds the scope of the ACA's EHBs is of critical importance because if a state enacts a new mandate that exceeds the scope of the EHBs, the ACA requires the state to reimburse the federal government for the resulting incremental increase in the cost of subsidies provided for coverage provided through the exchange.

After the Step 1 Assessment is presented, the HIRC determines if further assessment of a proposed mandate is warranted. If it does, JLARC and the BOI perform a Step 2 Assessment, which requires an analysis of the proposal's impact on services, providers, and the total cost of health care in the Commonwealth.

## Step 1 Assessments

Of the 10 bills referred to the HIRC during the 2019 Session, nine propose to ther establish a mandate for coverage of a health benefit or mandate payment for covered services to specified providers. The only bill referred to the HIRC that does not pertain to a mandate is Senate Bill 1362, which addresses balance billing for ancillary services. The Step 1 Assessments for the other nine bills were presented by Ms. Tompkins, as follows:

- House Bill 2710 (Campbell, J.L.) provides for direct reimbursement by a health plan to a law-enforcement agency that provides transportation to a covered person subject to an emergency custody order or a temporary detention order, if the health plan provides coverage for such transportation. As it involves a mandated provider, a determination of whether the bill would create a new mandated benefit that exceeds the EHBs was not applicable.

- House Bill 2598 (Hayes) and Senate Bill 1624 (Barker) provide that if a policy or contract that covers services that a registered surgical assistant may legally perform, equal coverage must be provided for such services when rendered by a registered surgical assistant. As the bills involve a mandated provider, a determination of whether they would create a new mandated benefit that exceeds the EHBs was not applicable.
- House Bill 2669 (Roem) would require coverage for medically necessary prosthetic devices and their repair, fitting, replacement, and components. Because Virginia currently requires carriers to offer coverage for prosthetic devices, the BOI characterized this bill as an extension of an existing EHB rather than as a new benefit for which the Commonwealth would be required to defray the cost.
- House Bill 2177 (Murphy) would require coverage for medically necessary formula and enteral nutrition products. The current benchmark plan covers infusion services, including enteral nutrition therapy. The BOI characterized this bill as an extension of an existing EHB rather than as a new benefit for which the Commonwealth would be required to defray the cost.
- Senate Bill 1010 (Black) would require coverage for long-term antibiotic therapy for a patient with Lyme disease when determined to be medically necessary and ordered by a licensed physician after making a thorough evaluation of the patient's symptoms, diagnostic test results, or response to treatment. The BOI reported that, pursuant to guidance from the Centers for Medicare & Medicaid Services, state mandates related to the coverage of specific drugs that goes beyond the number of drugs offered in the benchmark plan does not exceed EHBs. As a result, enactment of this mandate would not require the Commonwealth to defray the cost.
- House Bill 2049 (Carroll Foy) and Senate Bill 1650 (Howell) would require coverage for expenses incurred in the provision of pasteurized donated human breast milk. The BOI characterized this mandate as a new benefit exceeding the EHBs and as a result the Commonwealth could be required to reimburse the federal government for associated costs.
- House Bill 2601 (Plum) would require coverage for the billed charges of one hearing aid per hearing impaired ear in an amount not to exceed $3,000 per hearing aid for minors. Coverage for hearing aids is specifically excluded from the current benchmark plan. The BOI characterized this mandate as a new benefit exceeding the EHBs and as a result the Commonwealth could be required to reimburse the federal government for associated costs. Ms. Tompkins also noted that the bill purports to exempt plans offered through the exchange from the coverage requirements to the extent that it would require benefits that exceed the EHBs, while continuing to apply the requirements to plans offered outside the exchange. The ACA provides that state standards or requirements implementing, or related to, standards or requirements in Title I of the ACA must be applied uniformly to all health plans in each insurance market to which the standard and requirement apply. Therefore, this element of the bill appears to be inconsistent with the ACA.

The members discussed whether to direct the BOI and JLARC to conduct Step 2 assessments of these bills. The BOI undertook to prepare a work plan over the ensuing 30 to 45 days. The plan will propose an approach for the conduct of Step 2 assessments. The HIRC will review and act on the work plan at its next meeting.

## Other Legislation

Staff provided the members of the Commission with an overview of additional health insurance legislation from the 2019 Session that was not subject to a Step 1 Assessment by the Bureau of Insurance. Staff reported that the relevant stakeholders were not able to reach a consensus as to how the issue of balance billing in emergency service visits could be resolved going into Session, so numerous approaches were offered and ultimately failed. One bill addressing balance billing with regard to ancillary services, Delegate Ware's House Bill 2538, passed. It requires notice by a facility that some services may be provided by an out-of-network provider and that those services will be billed separately from the facility's charge. Additionally, seven bills relating to health insurance were vetoed by the Governor. The issues vetoed included benefits consortiums, also sometimes referred to as association health plans, short-term, limited-duration health plans, and catastrophic health plans.

---

For more information, see the *HIRC website* or contact the Division of Legislative Services staff:

Frank Munyan, Senior Attorney, DLS.
fmunyan@dls.virginia.gov
804-698-1816

---