HOUSE BILL REPORT
ESHB 1740

As Passed House:
March 4, 2011

Title: An act relating to the creation of a health benefit exchange.

Brief Description: Establishing a health benefit exchange.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Cody, Schmick, Jinkins and Hinkle; by request of Governor Gregoire).

Brief History:
Committee Activity:
Health Care & Wellness: 2/7/11, 2/17/11 [DPS];
Ways & Means: 2/23/11, 2/24/11 [DPS(HCW)].
Floor Activity:
Passed House: 3/4/11, 79-18.

Brief Summary of Engrossed Substitute Bill

- Requires the state to establish a health benefit exchange by statute.
- Establishes the parameters for a health benefit exchange board, to be appointed July 1, 2012.
- Requires the Health Care Authority, in collaboration with the Joint Select Committee on Health Care Reform, to apply for and implement federal grants and to provide options to the Legislature for establishing an exchange.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 10 members: Representatives Cody, Chair; Jinkins, Vice Chair; Schmick, Ranking Minority Member; Hinkle, Assistant Ranking Minority Member; Clibborn, Green, Harris, Kelley, Moeller and Van De Wege.

Minority Report: Do not pass. Signed by 1 member: Representative Bailey.

Staff: Jim Morishima (786-7191).

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.

HOUSE COMMITTEE ON WAYS & MEANS

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 25 members: Representatives Hunter, Chair; Darneille, Vice Chair; Hasegawa, Vice Chair; Alexander, Ranking Minority Member; Dammeier, Assistant Ranking Minority Member; Orcutt, Assistant Ranking Minority Member; Carlyle, Cody, Dickerson, Haigh, Haler, Hinkle, Hudgins, Hunt, Kagi, Kenney, Ormsby, Parker, Pettigrew, Ross, Schmick, Seaquist, Springer, Sullivan and Wilcox.

Minority Report: Do not pass. Signed by 2 members: Representatives Bailey, Assistant Ranking Minority Member; Chandler.

Staff: Erik Cornellier (786-7116).

Background:

Health Benefit Exchanges.

The federal Patient Protection and Affordable Care Act (PPACA) requires every state to establish an "American Health Benefit Exchange" (Exchange) no later than January 1, 2014. The Exchange must serve both small groups (in a so-called SHOP Exchange) and individuals and must be self-sustaining by January 1, 2015. If a state chooses not to establish an Exchange, the federal government will operate an Exchange either directly or through an agreement with a nonprofit entity.

Under the PPACA, an Exchange's functions include:
- facilitating the purchase of qualified health plans by individuals and small groups;
- certifying health plans as qualified health plans based on federal guidelines;
- providing information to individuals about their eligibility for public programs like Medicaid and the Children's Health Insurance Program and enrolling eligible individuals in those programs;
- operating a telephone hotline and website to assist consumers in the Exchange; and
- establishing navigator programs to help inform consumers and facilitate their enrollment in qualified health plans in the Exchange.

Health plans in the Exchange will be available in four different levels based on the percentage of costs the plan will pay: Bronze (60 percent), Silver (70 percent), Gold (80 percent), and Platinum (90 percent). In order to be qualified to sell insurance in an Exchange, a carrier must:
- be certified as a qualified health plan based on federal guidelines;
- provide coverage for essential health benefits, as defined by the federal government;
- offer at least one Silver and one Gold plan in the Exchange; and
- charge the same premium, both inside and outside the Exchange.

Premium subsidies on a sliding scale will be available in the Exchange for persons between 133 percent and 400 percent of the federal poverty level (FPL) in the form of advanceable, refundable tax credits. Depending on a person's income level, the subsidies will ensure that the premiums the person pays will be no greater than a certain percentage of the person's

income: under 133 percent FPL = 2 percent of income; 133-149 percent FPL = 3-4 percent of income; 150-199 percent FPL = 4-6.3 percent of income; 200-249 percent FPL = 6.3-8.05 percent of income; 250-299 percent FPL = 8.05-9.5 percent of income; and 300-399 percent FPL = 9.5 percent of income.

The PPACA provides states with some flexibility when implementing the Exchanges. For example:

- Administration: the Exchange may be administered by the state itself or a nonprofit entity.
- Basic Health Option (BHO): the state may contract with private insurers to provide coverage for low-income individuals between 133 and 200 percent FPL, similar to Washington's existing Basic Health Plan. Individuals in the BHO will not participate in the Exchange, but the state will receive federal funding for the BHO equal to 95 percent of the tax credits and cost-sharing reductions the individuals would have received in the Exchange.
- Regional or Interstate Exchanges: an Exchange may operate in more than one state. A state may also establish subsidiary Exchanges to serve geographically distinct areas within the state.
- One Exchange or Two: the state may operate separate Exchanges for the individual and small group markets, or may operate one Exchange that serves both (this is a separate issue from combining risk pools).
- Combining Risk Pools: the state may merge the individual and small group markets.
- Essential Health Benefits: the state may require insurers to offer benefits beyond what is required by federal law, but must pay for the increased costs of such benefits.

State Planning Activities.

In 2010 there was a variety of planning activities relating to Exchanges. For example, the Legislature established the Joint Select Committee on Health Reform Implementation, which established an advisory group to consider issues relating to establishing an Exchange. The Office of the Insurance Commissioner established a Realization Committee, which also made recommendations relating to an Exchange. Finally, the Health Care Authority (HCA) received a planning grant, which it used, in part, to develop several issue briefs relating to Exchanges.

Summary of Engrossed Substitute Bill:

Establishing an Exchange.

The state must establish, by statute, an Exchange no later than January 1, 2014. The Exchange is intended to:

- increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers;
- provide consumer choice and portability of health insurance, regardless of employment status;

- create an organized, transparent, and accountable health insurance marketplace for Washingtonians to purchase affordable, quality health care coverage, to claim available federal refundable premium tax credits and cost-sharing subsidies, and to meet the personal responsibility requirements for minimum essential coverage as provided under the federal Affordable Care Act;
- promote consumer literacy and empower consumers to compare plans and make informed decisions about their health care and coverage;
- effectively and efficiently administer health care subsidies and determination of eligibility for participation in publicly subsidized health care programs, including the Exchange;
- create a health insurance market that competes on the basis of price, quality, service, and other innovative efforts;
- operate in a manner compatible with efforts to improve quality, contain costs, and promote innovation;
- recognize the need for a private health insurance market to exist outside of the Exchange and the need for a regulatory framework that applies both inside and outside of the Exchange; and
- recognize that the regulation of the health insurance market, both inside and outside the Exchange, should continue to be performed by the Insurance Commissioner.

<u>The Health Benefit Exchange Board</u>.

The Health Benefit Exchange Board (Board) is established as a nonprofit, public-private partnership the membership of which will be appointed by the Governor by July 1, 2012. The membership of the Board must be as follows:

- two employee benefits specialists;
- a health economist or actuary;
- small businesses;
- health care consumer advocates;
- the administrator of the HCA;
- the Insurance Commissioner (as an ex-officio member); and
- two members from a list of four recommendations submitted by the Legislature. Each chamber of the Legislature must submit two names, which must be mutually agreed on by each caucus. The persons on the list must have expertise in at least one of the following areas: individual health care coverage; small employer health care coverage; health benefits plan administration; health care finance and economics; actuarial science; administering a public or private health care delivery system; or purchasing health plan coverage.

Board members may not be employed by, a consultant to, a member of the board of directors of, or otherwise a representative of or a lobbyists for an entity in the business of, or potentially in the business of, selling items or services of significant value to the health benefit exchange.

The Board must establish an advisory committee to allow for the views of the health care industry and other stakeholders. The Board may establish technical advisory committees and to consult with experts. In recognition of the government to government relationship

between the state and the federally recognized tribes, the Board must consult with the American Indian Health Commission on an ongoing basis.

Members of the Board are immune from civil or criminal liability for actions taken, or not taken, in the performance of their official duties, as long as they are acting in good faith. However, this immunity does not prohibit legal actions to enforce the Board's statutory or contractual duties or obligations.

Federal Grants.

The HCA must apply for establishment and planning grants under the PPACA in collaboration with the Joint Select Committee on Health Care Reform Implementation. Whenever possible, the grant applications must allow for using grant funds to partially fund the activities of the Joint Select Committee on Health Care Reform Implementation. The HCA, in collaboration with the Joint Select Committee on Health Care Reform Implementation, must implement any grants received by the federal government.

Exchange Options.

By January 1, 2012, the HCA, in collaboration with the Joint Select Committee on Health Reform Implementation, must develop a broad range of options for establishing and implementing a state-administered Exchange. The options must include recommendations on:

- the structure of the public-private partnership that will administer the Exchange, operations of the Exchange, and administration of the Exchange, including: the goals and principles of the Exchange; the creation and implementation of a single, state-administered Exchange for all geographic areas of the state that operates for both individual and small group markets; whether and under what circumstances the state should consider establishing a multi-state Exchange; whether the Exchange should serve as an aggregator of funds that compromise the premium for a health plan in the Exchange; the administrative, fiduciary, accounting, contracting, and other services to be provided by the Exchange; coordination with other state programs; development of sustainable funding as of January 1, 2015; and recognizing the need for expedience in determining the structure of needed information technology, the necessary information technology to support implementation of Exchange activities;
- whether to adopt and implement the BHO, whether the BHO should be administered by the entity that administers the Exchange, and whether the BHO should merge risk pools with any portion of the state's Medicaid program;
- individual and small group market impacts, including whether to: merge the risk pools in the individual and small group markets; and increase the small group market to firms with up to 100 employees;
- creation of a competitive purchasing environment for qualified health plans in the Exchange;
- certifying, selecting, and facilitating the offer of individual and small group plans in the Exchange;
- the role of navigators;
- effective implementation of risk management methods, including reinsurance, risk corridors, and risk adjustment;

- participating in innovative cost-containment efforts;
- providing federal refundable premium tax credits and reduced cost-sharing subsidies through the Exchange, including the processing and entity responsible for determining eligibility;
- the staff, resources, and revenues necessary to operate and administer the Exchange for the first two years; and
- any other areas identified by the Joint Select Committee on Health Reform Implementation.

In collaboration with the Joint Select Committee on Health Reform Implementation, the HCA must develop a work plan for the development of the options in discrete, prioritized stages.

Consultation with Other Entities.

The HCA must consult with the Insurance Commissioner, the Joint Select Committee on Health Reform Implementation, and stakeholders when carrying out its responsibilities, including consumers; individuals and entities with experience facilitating enrollment in health insurance coverage; representatives of small businesses, employees of small businesses, and self-employed individuals; advocates for enrolling hard-to-reach populations and populations enrolled in publicly subsidized health programs; health care providers and facilities; publicly subsidized health care programs; and members of the American Academy of Actuaries. The HCA may enter into information sharing agreements with federal and state agencies and interdepartmental agreements with other state agencies. The HCA must also provide staff and resources, manage grant and other funds, and expend appropriated funds.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) The PPACA requires the establishment of Exchanges by January 1, 2014. The state may develop its own Exchange or the federal government will operate one on behalf of the state. This bill creates a process for stakeholders to weigh in. This bill was informed by the work of the Joint Select Committee on Health Care Reform Implementation and the Insurance Commissioner's Realization Committee. A maternal and child health expert should be added to the board. The Exchange should coordinate with other federal programs. The bill should create a mechanism to work with the tribes. This effort should be housed in the HCA, which is accountable for the planning grant. There should be clarity about what comes back to the Legislature.

(In support with concerns) This bill allows the Exchange to be established as an active purchaser. The bill should go further than it has to include items for which there is general consensus; e.g., a single Exchange for administrative purposes. There should be no further

research on this type of issue. The bill should create the governing board, not an intermediate board. Insurance coverage should be provided to everyone in every corner of this state. There should be a high bar for participating in the Exchange. Issues relating to transportation, language access, and coordinated care should be addressed. Consumer literacy should be addressed; it is the best predictor of health outcomes. The Exchange should harness the bargaining power of small businesses and individuals to become a more active purchaser. There should be a public option in the Exchange. Establishment of an Exchange is critical for older people who are too young for Medicare. The Exchange should be an organized, transparent, accountable marketplace where people can compare apples to apples and access subsidies. Access to the Exchange should be seamless; the Exchange should be a one door access point for at-risk communities. There should be adequate consumer assistance in the Exchange. The Board should analyze the role of association health plans. The Joint Select Committee on Health Reform Implementation is no substitute for the Board. The composition of the Board should be expanded and stronger conflict of interest and stakeholder language should be included. The Board should be subject to the Open Public Meetings Act. There should be more detail on the appointment process to the Board. The business plan created by the Board should be submitted to the Legislature for further action. The Board should not go too far afield of what is funded by the federal grants.

(With concerns) The Exchange should not be a selective purchaser. Planning for the Exchange should be done through the Joint Select Committee on Health Care Reform Implementation, which is more inclusive and has a legislative component. When planning the Exchange, the details are critical. It is premature to establish the Board within the HCA. Some of the research done by the HCA takes a point of view, and it is premature to decide these complicated issues. It is important to foster a broad, bipartisan dialogue and foster the participation of people with expertise.

(Opposed) This bill removes the decision of how to establish an Exchange from the Legislature and puts it in the hands of unelected political appointees. Planning for the Exchange should be done through the Joint Select Committee on Health Care Reform Implementation, which is more open and inclusive. A bill is not needed for the executive branch to do this. By passing a bill, the Legislature is blessing the work of the Board.

Staff Summary of Public Testimony (Ways & Means):

(In support) Some aspects of the bill could be perfected, but it is important to move forward on health care reform and maintain eligibility for federal health reform funding. This bill should be revenue neutral and could even bring in revenue because it makes the state eligible for federal funding.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Jonathon Seib, Office of the Governor; Lonnie Johns-Brown, American Indian Health Commission and March of Dimes; and Karen Merrikin, Group Health Cooperative.

(In support with concerns) Jennifer Allen, Healthy Washington Coalition; Teresa Mosqueda, Washington State Labor Council; Sofia Aragon, Washington State Nurses Association; Kent

Davis, Main Street Alliance; Ingrid McDonald, Association for the Advancement of Retired Persons; John Paul Chaisson-Cardenas, Washington Community Action Network; Misha Werschkul, Service Employees International Union 775 NW; and Dave Knutson, United Healthcare.

(With concerns) Chris Bandoli, Regence Blue Shield; Mel Sorensen, American's Health Insurance Plans, Washington Association of Health Underwriters, and National Association of Insurance and Financial Advisors; and Sydney Smith Zvara, Association of Washington Healthcare Plans.

(Opposed) Patrick Connor, National Federation of Independent Business; and Scott Dahlman, Washington Farm Bureau.

Persons Testifying (Ways & Means): Jennifer Allen, Planned Parenthood and Healthy Washington Coalition.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): None.

Persons Signed In To Testify But Not Testifying (Ways & Means): None.